

PSYCHD

**Fighting for survival
patients' experiences of inpatient treatment for anorexia nervosa**

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**Fighting for Survival:
Patients' Experiences of Inpatient Treatment
for Anorexia Nervosa**

By

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*A thesis submitted in partial fulfilment of the requirements for the degree of
PsychD Counselling Psychology*

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Abstract

This study investigates patients and ex-patients experiences of inpatient treatment for Anorexia Nervosa (AN) across a variety of treatment locations and contexts. Adopting a social constructionist approach to grounded theory, data was collected through in-depth interview of 11 participants identified as white, cis-gender and female. This method enabled examination of the interactive processes and situational properties that influenced patients' perceptions and the social processes that emerged from them.

The core category 'Fighting for Survival' coheres two main categories that constitute the central findings of this study. Category A: 'The Feeding Clinic – Embedding Anorexia' and Category B: 'Empowering the person – Fighting the ED' reflect how participants accounts tended to present a split between positive and negative treatment experiences depending on how a service conceived the treatment objective and constructed the patient. These differences of context were found to generate vastly different interactive contexts and result in radically different treatment outcomes for a patient.

Treatment contexts defined as 'Feeding clinics' were found to establish a social order amongst patients and staff defined by distrust and hostility. Perceiving treatment as a coercive regime, profound feelings of disempowerment and desperation lead patients to adopt strategies of resistance that ultimately appeared to entrench patients eating disordered behaviours and identity. Treatment contexts defined as 'Person-Orientated' by contrast were found to help patients (re)gain a sense of their inherent value as a person and to adopt a conceptual framework towards the 'ED' that provided both the reason and the means by which patients could begin the process of establishing a recovery position.

Table of Contents

Abstract.....	2	
Prologue:	11	
 Chapter 1:		
Introduction.....	16	
The Necessity of Medical Care.....	16	
The Patients Perspective.....	17	
Methodological Focus.....	18	
Thesis Structure	20	
 Chapter 2: Literature Review.....		22
The emergence of Anorexia Nervosa.....	22	
AN Treatment During the 19th & 20th Century	23	
Socio-Political Constructions of Anorexia Nervosa.....	24	
The Role of Counselling Psychologists in Psychiatric Settings	26	
The Current Diagnostic Framework	27	
The Current Demographic Profile of AN Sufferers and Cross-cultural Definitions...	28	
The Prevalence of AN.....	29	
Current Methods of treatment.....	30	
Current Therapeutic Approaches.....	30	
Current Issues in Assessing Treatment.	30	
Treatment Efficacy and Outcomes	32	

Symptom Prognosis and Perseverance.....	33
Explanations for Treatment Failure.....	33
Inherent ‘Resistance to Treatment’ Reconsidered.....	34
Treatment Focus on Food.....	34
The Therapeutic Relationship within the Inpatient Context.....	35
Recommendations for Treatment Services.....	36
Qualitative Studies on Patient Perspectives.....	38
Conclusion and Study Rationale.....	39
Study Aims.....	40
Chapter 3: Methodology.....	42
Identifying my methodology.....	42
Interpretative Phenomenological Analysis.....	43
Discourse Analysis.....	43
Grounded Theory.....	45
The Historical Development of GT.....	46
Social-Constructionist Grounded Theory.....	47
A pragmatic Ontology and Relational Epistemology.....	49
Defining Reality.....	49
Understanding Human Behaviour: Constructing Meaning Through Social Interaction.....	51
A concept of Self and Identity.....	52
Centralising the Participant’s Perspective	53
Ethics.....	54
Validity and Reliability.....	55

Chapter 4: Method.....	56
Choosing Interview as a Means of Data Collection.....	56
Data Recording and Protection.....	57
Sampling Methods and Recruitment.....	57
Inclusion Criteria and Demographic Profile.....	58
Ethical Considerations.....	59
The Interview	60
Negotiating Power and Disclosure.....	60
Interview Protocol.....	62
Data Analysis.....	63
Theoretical Sampling and Interview Evolution.....	64
Coding and Categorisation.....	65
Research Validity.....	67
Methodological Reflections.....	68
Summary.....	70
 Chapter 5: Data Analysis Results.....	 71
Overview of the Findings.....	72
Category A “The Feeding Clinic”: Embedding Anorexia’.....	73
<i>Theme a) Medical Model Framework.....</i>	<i>73</i>
<i>a) 1. Standardisation.....</i>	<i>74</i>
<i>a) 2. Pathologisation.....</i>	<i>80</i>
<i>a) 3. Fast-Tracking Weight-gain: “Weight-gain - that’s all they care about”</i>	<i>85</i>

<i>b) 1. Providing Physical Safety.....</i>	123
<i>b) 2. Integrating Communication.....</i>	124
<i>b) 3. Relational Connection.....</i>	126
<i>b) 4. Non-Punitive Control: “Tough-Love”</i>	127
Theme c) A Place for Self-Development.....	128
<i>c) 1. Differentiating self from Illness.....</i>	129
<i>c) 2. Providing a full therapeutic programme: ‘It’s the feelings not the food’...133</i>	
Theme d) Repositioning for Recovery.....	135
<i>d) 1. Cultivating Hope.....</i>	136
<i>d) 2. “Doing it for oneself”</i>	137
<i>d)3. Establishing Self-Management Strategies</i>	138
 Chapter 6: Discussion.....	141
Medicalisation: A Discourse of Resources.....	141
The Abjection of Emotion.....,,,	143
Providing Psychotherapy within the Inpatient Context.....	144
The Continued focus on Weight, Food and Eating.....	145
A Culture of Rationing.....	145
Humanisation: A Discourse of ‘personhood’, Resources of ‘Time’ and ‘Social Capital’	147
Cultivating a Sense of Human Value.....	147
Respect and Validation.....	148
Investing in Psychotherapeutic Provision.....	149
The Importance of a Collaborative Ethos.....	149
The Issue of Autonomy.....	150

The Implications of Patients Disempowerment.....	153
Dis-ordered Treatment	154
A Battle for ‘control’	155
<i>Strategies of Resistance</i>	156
<i>Resistance Reconsidered</i>	157
The Disembodied Self.....	158
A Socially Critical Treatment Model.....	159
Differential Meanings of Control.....	159
Staffs’ Capacity to Work with Negative Emotion and Anger.....	160
Distinguishing Self from ED.....	161
Recognising Specific Staff Skills.....	164
Theoretical Reflections.....	166
Maintaining the notion of a ‘Real self’ alongside a Multiple-self model of the Psyche.....	166
The Split in the Study Findings.....	166
Defining Services as ‘Person-Orientated’	169
Study Limitations.....	171
Use of Psychiatric Discourse within this Study.....	171
Context Specific.....	172
Theoretical Sampling.....	173
Examining Patient to Patient Interactions.....	174
Summary of Findings.....	175
Study Findings In Relation To Previous Literature.....	176
Study Implications	180
Suggestions for Future Research.....	183

Final Reflections.....	184
Appendices.....	185
Appendix 1. The Context in which Anorexia Nervosa was ‘Discovered’	185
Appendix 2. The Challenge to Psychiatry and Evolution of Psychiatric Practice.....	186
Appendix 3. Socio-Political Constructions of Anorexia Nervosa.....	188
Appendix 4. A Psychiatric Construction of AN.....	190
Appendix 5. Diagnostic Criteria for Anorexia Nervosa.....	191
Appendix 6. Cross-cultural studies finding AN as an ‘ego-syntonic’ condition.....	193
Appendix 7. Constructivism and Constructionism.....	194
Appendix 8. Recruitment Email.....	196
Appendix 9. Recruitment Poster.....	198
Appendix 10. Information sheet for Participants.....	199
Appendix 11. Check List inclusion/exclusion criteria.....	204
Appendix 12. Demographic Questionnaire.....	205
Appendix 13. Consent Form.....	207
Appendix 14. Demographic Graph	211
Appendix 15. Debriefing Sheet & Follow up Support for Participants.....	212
Appendix 16: Interview Question Outline.....	218
Appendix 17. Theoretical Saturation.	220
Appendix 18. Example of Initial/Line by Line/Open coding.....	221
Appendix 19. Example of Focused Codes.....	228

Prologue: Personal Reflections on the research process

The title of this thesis ‘Fighting for Survival’ not only signifies the ‘core category’ that provides coherence and integration to the study findings. The notion of ‘Fighting for Survival’ also serves to highlight the imminent prognosis that patients face in finding themselves admitted to an inpatient clinic for an eating disorder: most participants of this study entered treatment due to the life-threatening effects of starvation and were confronted with likely death if they failed to challenge and overcome their eating disorder. The title simultaneously recognises the seriousness and difficulty of the recovery process itself. Re-emerging from a position of ‘near-death’ to re-assume a physiological state of relative health poses an enormous personal challenge and demands a person harness resources they often feel they don’t possess.

This acknowledgment is born from understanding how powerful and overwhelming the grip of an eating disorder to be when it has developed this far and is rooted in my own experience of confronting this place sixteen years ago. Whilst my memory is much faded, I remember grasping the need to fight on a psychological level, throughout and beyond the treatment process, to make an initial and then long-lasting physical recovery.

The idea of undertaking this research arose when I was an inpatient and fellow patients told me about their experiences of treatment elsewhere. These first-hand accounts, filled with images of cruelty and feelings of terror, shocked me, seeming to echo a quality of the Victorian asylum I thought had disappeared long ago. The lack of voice these patients felt about their experiences appeared to deepen their fervour about the ‘wrongness’ of what they had experienced and in me generated a desire and commitment to the idea that patients experiences of inpatient practice required representation and further investigation. My re-encounter with the inpatient service I had once been a patient of 10 years later as a visiting

‘recovered patient’ reconnected me with this past and led me to feel that I could make a unique difference in this field on account of my concurrent position as both a practitioner and ex-patient. In undertaking the Psych D in Counselling Psychology, my interest to undertake this specific research enquiry emerged from this personal history. Furthermore, upon reviewing the literature on patients experiences of inpatient treatment, I found that very few studies existed on this topic at all. Wading through an abundance of studies examining treatment outcomes through analyses of patient characteristics, I finally discovered some discourse analytic research which examined the contextual elements of inpatient treatment through critically illuminating prevailing discourses emerging within them. This review revealed that the research I had in mind had not been undertaken before. Research centralising the objective to give voice to patients experiences of inpatient admissions and to examine the interactional space of treatment delivery from the patients perspective presented a pressing gap in the literature. This lead me to believe that this study could meaningfully contribute to our current understandings of inpatient services for people with eating disorders.

I write these personal reflections on account of my awareness that "where you stand will doubtless help to determine not only what you will research but how you will research it" (Punch, 1994:94). "The beliefs, experiences and skills brought to the research [therefore] need to be made explicit, not with the intent of uncovering bias—a "misplaced term"—but to use as a resource to guide data gathering and interpretations" (Olesen, 1994:165). Indeed, throughout the research process, I have been aware that my own experience has tuned my ear to participants voices in particular ways and informed my understanding of the data. This influence I view as inevitable and unavoidable and, in the main, an advantage rather than disadvantage. As Rowling (1999) states: "subjectivity, rather than being a hindrance...[is] vitally important to begin to develop an understanding of...[participants'] experiences and...

a key element in researching sensitive issues” (p.175). This orientation to research has been emphasised by many feminist researchers (Oakley, 1981; Stanley & Wise, 1991) who consider that "personal involvement is...*the condition* [my italics] under which people come to know each other and to admit others into their lives" (Oakley, 1981:58). Conversely, I propose that a detached perspective and so called ‘objective’ self-positioning within the research process would not elicit the information from participants nor yield the insight during analysis that could adequately recognise or value to the emotional and experiential nature of participants’ experiences. An ‘objective’ stance would have posed a considerable problem for me not only because of my personal history, but because the emotionality of the participants’ narratives, as supported by the interview relationship, was an important element of the research process (also see Rowling, 1999).

The main ‘vested interest’ informing this research is my heart-felt view that patients, deluded and ill as they may be, are still persons and need to be treated as such if they are to process and heal the pain they are in. This perspective clearly informs this paper. As I will demonstrate, there appears to be a polarised debate that has energised the field of ‘mental health’ for many decades regarding the status and construction of ‘the mental health patient’: at one end deemed unqualified for ‘reasonable’ intercourse and devoid of faculties constitutive of personhood, and at the other end, as a person who comes to embody and express the ills, wrongs or unacknowledged nature of society and those among it. Whilst I briefly portray this debate through the opposing positions advocated within psychiatry and anti-psychiatry literature, and this ‘split’ re-emerges within participants accounts of their treatment experiences, I nevertheless maintain the view that psychiatry as an institution holds the ability to bestow great value on those they strive to care for and wish to support this endeavour.

My own experience of ‘Anorexia Nervosa’, the function it served me and the way I engaged with the treatment process itself bore little resemblance to the participants of this study, which only attests to the variation amongst those who adopt similar strategies for coping with life and the different ways people negotiate social environments and undergo change. The considerable distance of time that has elapsed between my own encounter with this condition and this project lent me a deep sense of curiosity rather than assumption about participants’ experiences. Without doubt, the participants I interviewed experienced much more enriching and much more damaging experiences than I ever encountered whilst an inpatient myself. Their narratives therefore struck and surprised me continuously and I have done everything in my power to represent their voices and their truths, not mine, in this research.

Journal keeping through the process of memo-writing facilitated the documentation of my reflexivity throughout the research process. This is considered by many to be “a vital technique for qualitative researchers” as it provides “a means of highlighting theoretical perspectives, preconceptions and assumptions” and therefore “fulfils a technical function helping to maintain rigour in the research” (Rowling 1999:179; also see Crabtree & Miller, 1992; Denzin, 1994).

The Research Process

I was unprepared for the emotional impact this research would have on myself. Whilst I found the interview process to be fascinating and enriching, this did not signify the greatest challenge, possibly on account of my therapeutic skills of counselling psychology practice wherein I have developed the ability to offer an empathic position whilst withholding disclosure and bypassing internal involvement with my own experience from the listening and dialogic process. The personal challenge arose most powerfully in the transcription and

cyclical process of re-listening and re-reading the data. Here the pain emerging from all forms of participant struggle, in both positive and negative directions, was felt by me acutely. As I mention later in the paper, this slowed down my analysis as I worked to process these feelings and regain an analytic perspective. I cannot say if this material would have affected another so strongly as one who had not once been in a similar position to that of the participants'. I can say that my recognition of participants' intelligence, humanity and worth deepened this response.

The analytic process therefore took me more time than I had expected. As I strove to ensure the analytic narrative I was constructing was 'true' and inclusive to all participants experience, I felt frustrated with the Grounded Theory method which seemed to demand I fracture each account into indecipherable, coded segments, which I felt betrayed the full meaning of their experiences. To overcome this, I returned to the methodology to repeat the analysis several times. This helped me to ensure I was grasping the methodology with rigour and accuracy, whilst capturing the underlying qualities and issues that emerged as central to participants experiences of inpatient treatment.

Chapter 1. Introduction

The current management of those diagnosed with ‘acute’, ‘severe’ or ‘enduring’ Anorexia Nervosa (AN) within the psychiatric domain has emerged from a history spanning almost 150 years since its ‘discovery’ as a pathological category requiring psychiatric treatment.

Over this period, research on AN and its treatment documents developments in diagnostic, etiological and methodological perspectives according to progressive changes within society’s institutional management of mental health. Despite the continued support and perseverance of psychiatry’s medical model as the primary domain to which sufferers of AN are referred and managed, this ever-expanding field has not yet found a ‘cure’ nor identified a reliably effective method of treatment. Meanwhile, people continue to suffer from this condition in ever increasing numbers and psychiatric services currently appear to be struggling with both the clinical and methodological demand of providing and developing an effective approach that helps these patients to recover.

The Necessity of Medical Care

The mortality risk of those in a state of starvation is very concerning for all those responsible for the care of people admitted to inpatient treatment for AN. Frequently, patients undergo short periods within hospital for medical stabilisation before being transferred to inpatient units. Yet within the inpatient setting, patients’ low weights can still render them vulnerable to collapse. Having often endured years of living critically underweight, the loss of further weight at such a low threshold can cause risk of internal organ or heart failure. Inpatient clinics of AN therefore constitute a hospital setting in both medical and psychiatric terms and it is understood to be necessary for treatments to be overseen by specialist medical physicians

who can manage the physical aspects of a patient's wellbeing: such institutional establishments are held primarily responsible for the life and death of its patients.

From the clinical point of view therefore, inpatient treatment's central objective is to ensure medical stabilisation by restoring the physical health of the patient through nutritional treatment and weight-gain. The coercive measures often taken to achieve this objective (Valenti, Giacco, Katasakou & Priebe, 2014), alongside the frequent failure of generating an outcome whereby patients sustain the weight gained in treatment (Garner & Garfinkel, 1997), has been understood to indicate that these treatments fail to adequately address the psychological aspects of the condition (Bell, 2003; Malson, Finn, Treasure, Clarke & Anderson, 2004; Malson & Ryan, 2008; Ward, Troop, Todd & Treasure, 1996; Wilson, Fairburn & Agras, 1997; Colton & Pistrang, 2004; Sesan, 1994). This has raised concern about treatment protocols and generated motive to develop improved treatments for eating disorders. The current study contributes to this project by examining the inpatient treatment of eating disorders through an inductive method to provide new insight with the aim to improve treatment outcomes and recovery prognosis.

The Patients Perspective

Despite an expansive body of quantitative research examining AN and its treatment, categorising patient and treatment variables to measure and predict treatment outcomes, the lack of enquiry into patient perspectives has been criticised as constituting “a weakness in developing theory and clinical practice” (Hepworth, 1994:179). Researchers therefore advocate the need for more studies examining patient perspectives to enrich and supplement the information gathered by more standardised methods (Malson, Bailey, Clarke, Treasure, Anderson, Kohn, 2011; Boughtwood & Halse, 2008; Vandereycken & Devidt, 2010; Smith

et al., 2016). This study responds to this call with the hope of raising the audibility of patients' voices within research on AN inpatient treatment.

This study will examine how treatment is delivered to highlight the interactive, contextual factors that may be contributing to poor treatment outcomes. This will be achieved by exploring how eating disorders are experienced, understood and approached within treatment from the patients' perspective. This research thus asks, not 'why do people starve themselves?', nor 'what features of 'the illness' obstruct recovery?', but 'what is required of a treatment service to assist a person's recovery?', 'what role does treatment play in a person's recovery or lack of recovery from their condition?', 'what aspects of treatment do patients' find unhelpful or obstructive for their recovery?' and 'what do patients experience as helpful and constructive about treatments that successfully support patients' healing process?'.

Methodological Focus

In attempting to answer these questions, I will apply social-constructionist theory, underpinned by a symbolic interactionist perspective and pragmatic philosophy that enable an inductive investigation of the relational dynamics embedded within treatment practices. Glaser and Strauss, the founders of the Grounded Theory (GT) method writes: "In so much writing about interaction there has been such neglect...of relationships between social structure and interaction" (Glaser & Strauss, 1966:284). The GT paradigm, he explains, "forces one's gaze upon two important features of interaction that are frequently underplayed. One feature is the developmental character of interaction. The second is the social structural context within which interaction occurs" (p.284). The current study focuses specifically on these two domains of empirical enquiry. This perspective considers the environmental factors that may be influencing or cultivating certain behaviours or experience

in a person. This inevitably generates a critical perspective to more traditional frameworks using statistical and deductive methodologies which focus on characteristics of the individual to account for a person's behaviour or experience. The tendency of such 'objective' research is to omit account of the relational factors that influence a person's behaviour and fail to acknowledge the contextual influences and 'biases' by which they construct scientific 'truth'. Redressing this, the GT method insists the researcher consider contextual factors as possible conditions influencing social interaction (Strauss & Corbin, 1994). GT's assumption that people are always in a process of evolution informs the research question: 'In what direction are patients changing while undergoing residential treatment for AN and what interactional, social, relational phenomena are informing or influencing these evolutions of self?'.

GT's facility to construct theory from participants lived experiences (Fassinger, 2005) further recommends this method as suited for the objective of this particular study, as well as being an appropriate methodology for Counselling Psychology in general, which, as a discipline, maintains an existential and humanistic claim on the need to respect and respond to the client's unique perspective as the primary basis upon which any treatment can proceed (Woolfe, Dryden, Strawbridge, 2003). As the researcher, my aim is to represent and reflect, as faithfully as possible, the patient's experiential knowledge about their experiences of residential treatment as a valid form of empirical data.

This research will proceed to develop a theoretical construct, with simplicity of structure and coherence of findings. The movement from coded data towards an abstracted theory echoes the analytic direction developed by Glaser and Strauss (1967). These accounts are not generalised to claim universality. However, the rigour of the analysis procedure, the consistency and robustness of the findings, and the arguments within which I embed them aim to provide a convincing account of a theory, which I offer to the field as insight to be considered for developing current treatment practices. The impact of this study depends

therefore on the common-sense presentation of material and the utility with which it can be applied in the service of clinicians undertaking the task of treating people with severe eating issues.

Thesis Structure

Following this introduction, chapter 2 explores the existing literature related to this study. Unlike previous GT methods, SC-GT recognises that the researcher necessarily and unavoidably approaches the study with prior knowledge and experience. SC-GT therefore permits the researcher to conduct an initial literature review to provide greater contextual understanding of and rational for the proposed study. The literature review will continue throughout the analysis as theoretical concepts are constructed (Charmaz, 2006).

Chapter 3 considers the ontological and epistemological assumptions underpinning this study's enquiry and provides rational for using a SC-GT methodology.

Chapter 4 outlines the research design, accounts for ethical considerations and chronicles the rigorous analytic procedure that generated the substantive grounded theory presented in this thesis.

Chapter 5 presents the research findings. Data analysis proceeds alongside quotation from the participant's interview transcripts and 'in vivo' text throughout, as indicated by double quotation marks and indented text. Owing to all participants' location as patients or ex-patients of inpatient treatment I shall refer to participants or patients interchangeably throughout the analysis and discussion chapters for the purpose of clarity in meaning and writing style. Following Charmaz's (2006, 2014) methodology, I integrate relevant literature throughout the analysis to contextualise the current findings.

Chapter 6 summarises the emergent grounded theory and discusses the research in light of literature pertaining to these findings. I then reflect on my theoretical decisions and

discuss the study limitations. I conclude with recommendations for inpatient treatment practices and suggested avenues for future research.

Chapter 2: Literature Review

In this chapter I review the literature concerning the emergence of AN as a form of pathology and object of psychiatric treatment. Considering the cultural, clinical and academic domains through which AN has been constructed and understood, I first trace how AN became a category of psychopathology within the burgeoning field of psychiatry in the 19th Century alongside its formulation as a distinctly female pathology (Malson, 1998). I then briefly trace the development of treatment for AN through subsequent societal and ideological changes, reflecting shifts both in cultural perceptions of psychiatry as a social institution and in diversifying formulations of AN according to contemporary cultural forces and trends. I then provide a review of AN as currently defined within the diagnostic framework, treatment methods and evaluate AN treatment efficacy. Finally, I identify gaps in the literature on the treatment of AN, providing a rationale for this study.

The Emergence of Anorexia Nervosa

The phenomena of AN emerged within the context of the late 19th Century. This era marked the establishment of enlightenment philosophies and rise of empiricism in which the medical sciences became regarded as the rightful domain for understanding and treating psychological phenomena (Hepworth, 1999) (see Appendix 1. for further discussion).

Gull and Lasèque, physicians studying dysfunctions of the gastric system in the 1850s & 60s made the first reference to a condition marked by the severe loss of appetite, describing a ‘form of hysteria of the gastric centre’ (Lasèque, 1873:265). Initially named “Apepsia Hysterica” (Gull, 1873), their failure to identify organic causation¹ supported the conclusion that women’s loss of appetite was inexplicable to the rational mind and thus

¹ Anorexia Nervosa receded as a psychiatric category between 1900-1930, owing to its confusion with Simmonds disease. AN re-emerged as subject of psychiatric treatment in the 1940s.

attributed to ‘a morbid mental... perversion’ (Gull, 1874:24). The condition was subsequently re-classified as a ‘nervous’ disease specific to women under the term ‘Anorexia Nervosa’.

Despite the apparent cultural ubiquity of the construction of the ‘nervous woman’, working class and immigrant women were frequently excluded from ‘nervous femininity’ and considered capable of enduring severe deprivation and continual hard work without ill effects (Veith, 1965, cited in Malson, 1998:59). Anorexia was therefore constituted as a distinctly middle or upper-class female phenomena, located as a ‘bourgeois’ female ‘malady’ and endowed with etiological explanations pertaining to trivial, whimsical female desires (see Lasèque, 1873). By combining both the ‘hypothesis of neurosis’ and the ‘hysterical doctrine’ AN was simultaneously produced as “a real neurological disorder and a fictitious result of women’s obstinate irrationality” (Malson, 1998:74). The phenomena of ‘Anorexia Nervosa’ was thus gendered according to the “feminisation of the patient and the pathologisation of ‘woman’ in general” (Malson, 1998:75). Concurrently, the 19th C saw a sharp increase in the social organisation and surveillance of populations², in which asylums and psychiatrists came to seem essential and necessary (Szasz, 1974) and, as Hepworth (1999) documents, “it was to this emerging secular religion of medicine that those individuals who starved themselves were increasingly confined” (p.20).

AN Treatment During the 19th & 20th Century

Once diagnosed with AN, women were commonly prescribed a treatment of enforced passivity in the form of ‘the rest cure’ (Hepworth, 1999) with the objective to establish

² Between 1847-1914 the state-supported asylum system in England saw a massive growth, in which institutions increased in number from 21 to 97, housing an increase from 500 to 108,000 ‘lunatics’ over same period (Scull, 1993).

normal body weight and metabolic rate. “The patient”, Gull instructed, “should be fed at regular intervals and surrounded by persons who would have moral control over them” (Gull,1874:26). Through imposing institutional forms of normality, approvable behaviour and encouraging compliance, “the complete control of the patients’ behaviour and environment by the physician was intended to lead to the development of self-restraint and a return to mental equilibrium” (Foucault, 1965; Scull, 1981, cited in MacSween, 1993:14). Furthermore, whilst under constant medical observation, “all behaviours and actions could be defined as being symptomatic of AN according to medical scientific discourse” (Hepworth, 1999:38) whilst considering the patient to have relinquished her right to autonomy (Gert, Culver, 1979; McKinstry, 1992).

Socio-Political Constructions of Anorexia Nervosa

Alongside the proliferation of psychiatric practices during the 20th Century³, the profession’s claim to scientific objectivity and humanitarian intervention were challenged and criticised by anti-psychiatrists, who deconstructed the idea of ‘mental illness’ and re-theorised psychiatric practices as regulatory institutions operating to safeguard a political status quo (e.g. Parker, Georgaca, Harper, McLaughlin, Stowell-Smith, 1995; Malson et al., 2004) (see appendix 2 for further discussion). Concurrently, 1st and 2nd wave feminists employed qualitative methodologies to develop socio-political perspectives examining how gender inequalities both accounted for women’s psychological distress and were being perpetuated within psychiatric practices (see appendix 3 for further discussion).

Feminist discourses conceptualised AN as an expression of both cultural pressures upon women to achieve success and of their distress through body control. Thus challenging the established psychiatric view of AN as individual deviance, feminist theory presented the

³ Clinical experimentation proliferated during the mid 20th Century, in which using new technologies such as lobotomy, leucotomy, insulin shock therapy, electroconvulsive therapy became common treatments for psychiatric conditions considered to be intractable including AN (Hepworth, 1999; Gull, 1874).

condition as a symptom of problematic contemporary expectations for females (Steiner-Adair, 1986). While it is clear that the later stages of starvation effect profound changes in the body and mind (Aneurin Bevan Health Board, 2009), Button (1993) declares that feminist theories:

reveal how the *absolute* distinction between ‘normal dieting’ and primary anorexia is based upon broad assumptions about the ‘anorectic personality’ and, to the extent that psychiatric theory and method reify the anorectic condition as separate from culture, the discipline of psychiatry participates in the cultural scapegoating of ‘deviant’ females for what is arguably a problem of social structure and ideology (p.57).

These arguments and debates reflect how the construction and subsequent treatment of people with mental health issues has become, and continues to be, a polarised and politicised arena in which psychiatric theories and practices are contested and defended by theorists and researchers. Socio-political discourses however remain marginalised within the field of psychiatry and appear to have little impact on perspectives towards addressing AN within clinical contexts (Hepworth, 1999). Regarded as inferior to biomedical theories, these frameworks of analysis are subsumed within psychiatric discourse by “collapsing the complexity and diversity of social practices into pre-existing explanatory frameworks” (Hepworth, 1999:51) to be viewed as ‘influences’ or ‘factors’ in individual psychopathologies. Gremillion (1992) argues that this process applies to a wide range of psychological theories which have been incorporated within the psychiatric framework without significantly altering it.⁴

⁴ Gremillion (1992) discusses how psychological paradigms are assimilated into the prevailing psychiatric framework. She argues that while psychoanalytic theory “attends to the interpersonal, [it] reproduces the

Thus, whilst the psychiatric perspective has broadened its theoretical foundation beyond the purely medical and integrated the biopsychosocial model (Engel, 1977) into its diagnostic framework, psychiatry has continued to focus on discovering causes⁵, identifying clinical features and prognosis, and on assessing treatment in terms of numerical outcomes (Malson et al., 2004). Whether Anorexia is explained in terms of cognitive biases, maladaptive attitudes and behaviours, physiological dysfunction or even the psychodynamics of a person's relational history, psychiatry firmly locates the origin of the problem within the individual woman rather than her social context (Malson and Ussher, 1996a) (See Appendix 4 for extended discussion).

The Role of Counselling Psychologists in Psychiatric Settings

Clinical Psychologists have been employed in inpatient settings since the early 20th Century and now constitute a key member of multidisciplinary teams providing treatment. Their role often involves diagnosis, psychological and functional assessment, monitoring psychopathology, developing and delivering therapeutic programmes (particularly modalities of CBT and psychoeducation), motivational interviewing, skills training, research and contributing to treatment planning. Representing a younger profession, Counselling psychologists have more recently been incorporated into these settings, undertaking a similar

concept of mental illness as an internal, intrapsychic phenomenon (id) and retains the notion of the passive individual (ego)" (p.62). Behavioural psychology, she explains, renders the anorectic as "passively shaped from the outside" and "conditioned by environmental reinforcements" (Gremillion, 1992:62). Rather than understand the aetiology or dynamics of the disorder, behaviourists "[focus] instead on the design of treatment procedures" (Bemis, 1978:602), developing a model of control in which AN patients receive "'positive reinforcement' for weight gain and 'negative reinforcement for weight loss'" (see Garfinkel et al., 1973), whilst "the value of a quick 'cure' in the form of hospitalised weight gain goes unquestioned" (Gremillion, 1992:63). Psychodynamic theories, despite establishing the notion of an active ego, "have capitalised on the 'weak ego' concept of psychoanalyses, emphasising that this ego needs to be strengthened. Thus "while the psychodynamic approach...[offers] a collaborative and personalised philosophy, its analyses of the anorectics 'deficiencies' reveal a subtle, continued displacement of social and cultural norms to the individual anorectic psyche" (Gremillion, 1992:63).

⁵ Harnessing developments from the burgeoning field of neuro-biology and the cognitive-behavioural sciences, research now provides evidence, for example, of anorexics' 'low cerebral functioning', offering an empirically verified basis for the organic effects of AN, alongside claims that 50-80% of the risk for anorexia and bulimia is genetic (Trace, Baker, Peñas-Lledó, Bulik, 2013).

role to that of clinical psychologists. Counselling Psychologists' training is underpinned by an existential, relational and social constructionist philosophy alongside freedom to train in contexts outside the NHS. Together these influences may contribute to an approach to mental health distinct from that presiding in psychiatric services, which tend to adopt a medical or, more recently, biopsychosocial approach. Counselling Psychologists role and distinct construction of mental health therefore pose an interesting addition to the clinical team working within these contexts. There is currently, however, little research exploring how counselling psychologists negotiate their roles or philosophy of mental health within psychiatric services, or adapt to environments predominantly shaped by a medical discourse and framework of treatment. It is possible that the discourse appropriated by practitioners within these settings (supported by legal requirements and institutional protocols) render the counselling psychologist's difference of background negligible within such contexts since professional obligations command assimilation to the prevailing status quo. On the other hand, it is equally likely that Counselling Psychologists are supporting clinical innovation. This research aims to support this possibility and to demonstrate the contribution of Counselling Psychology research in developing clinical practice within psychiatric settings.

The Current Diagnostic Framework

Currently, the psychiatric diagnostic manual defines mental disorders as:

Syndromes comprising clinically significant disturbances of cognition, emotion or behaviour that reflect underlying dysfunctions characterised by clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. (DSM-5, 2013:20).

The manual specifies that “neither deviant behaviour...nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual” (DSM-5, 2013:20) By definition therefore, ‘mental disorder’ does not articulate with human relations or cultural conflict (Gremillion, 1992). Instead, the DSM defines AN according to observable variables alongside narrow etiological assumptions regarding the occurrence of symptoms. Herein AN is framed as the successful pursuit of thinness through dietary restriction and other measures, resulting in a body-weight below the normal range (Wilson, Grilo, Vitousek, 2007). Diagnosis is therefore given when individuals (male or female) have a body mass index (BMI) equal to or below 17.5 kg/m² and ‘refuse’ to maintain a minimally normal body-weight. Psychologically, the individual is understood to “display an intense fear of gaining weight or of becoming fat” and “self-esteem...highly dependent on their perceptions of body shape and weight” (DSM-5, 2013:340; See Appendix 5. for full criteria). Until 2013, amenorrhea (the cessation of menstruation) also constituted a key diagnostic indicator of the illness in females (DSM-IV-TR, 2000; DSM-IV, 1994; DSM-III-R 1987; DSM-III, 1980).

The Current Demographic Profile of AN Sufferers and Cross-cultural Definitions

Despite the recent emergence of AN across gender categories⁶ incorporating male and transgender groups, the gender-bias in female diagnoses, 90-95% being girls and young women (Gidwani & Rome, 1997; Hsu, 1989), identifies the continued manifestation of AN

⁶ The National Institute of Health and Clinical Excellence estimates around 11% of those affected by an eating disorder are male (NICE, 2004), whilst more recent studies show estimates between 10-25% (Sweeting, Walker, MacLean, Patterson, Räisänen, Hunt, 2015). In a large national study of college students, 16% of transgender college students reported having an eating disorder. (Diemer et al, 2015)

(and eating disorders more broadly) as a definitively ‘female’ issue. Additionally, whilst numbers rise across all socio-economic groups (Dolan, Lacey, Evans, 1990; Rhea, 1999; Wardle, Bindra, Fairclough, Westcombe, 1993) this population continues to represent predominately young, white, middle-class groups (Lucas, Crowson, O’Fallon, Melton, 1999; Hsu, 1989; Rieger, Touyz, Swain, Beumont, 2001). The recent spread to non-white, non-middle-class women has been interpreted by some as a consequence of the increased acculturation of Western values (Pumariega, 1986) and dissemination of ‘thinness’ as a cultural ideal of female beauty (Edwards-Hewitt & Gray, 1993).

Researchers questioning this view of ED’s as ‘culture-bound’ identify that “‘fat phobia’ may not be the *raison d’être* for all cases of morbid self-starvation” in non-western societies (Lee, Ho, Hsu, 1993; Banks, 1992). These cross-cultural studies nevertheless identify AN’s ‘ego-syntonic’ nature, in which extreme emaciation is perceived by the patient as highly valued (Theander, 1995) (see Appendix 6 for a fuller discussion). Herein, fat phobia becomes “but one manner in which emaciation is ego-syntonic” (Reineke, 1990), indicating that cross-cultural studies of self-starvation corroborate the pre-established conception of Anorectic presentations.

The Prevalence of AN

Whilst prevalence rates are hard to determine (Anorexia & Bulimia Care, n.d) there is general consensus that AN diagnoses have increased dramatically since the 1960s and are reaching epidemic proportions in Europe and North America (Gordon, 2000; Nasser, Katzman, Gordon, 2003). It is estimated that at least 30 million people of all ages and genders suffer from an eating disorder in the U.S alone (Hudson, Hiripi, Pope, Kessler, 2007; Le Grange, Swanson, Crow, Merikangas, 2012) and signifies their “third most common chronic illness among females” (Fisher, Golden, Katzman, Kreipe, Rees, Schebendach,

Hoberman, 1995; Lucas, Beard, O'fallon, Kurland, 1991). Additionally, eating disorders are seen to be spreading to cultures which were previously believed to be unsusceptible to it (Gordon, 2001). Regarding inpatient treatment in the UK, figures from the Health and Social Care Information Centre (2014) show a national rise of 8 per cent in the number of admissions to hospital for an eating disorder.

Current Methods of treatment

Hospitalisation is the primary mode of treatment when the anorectic is medically compromised (McKenzie & Joyce, 1992; Vandereycken, 2003) and primarily attends to medical stabilisation through weight-gain (Boughtwood & Halse, 2008; Jarman, Smith, Walsh, 1997). Within inpatient contexts, it is typically recommended that patients should gain 1 – 1.5 kg per week (Vandereycken, 2003). This is achieved through various means, including supported meals, nasogastric tube feedings, total parenteral nutrition and surgical interventions (Halse, Boughtwood, Clarke, Honey, Kohn, Madden, 2005; Neiderman, Farley, Richardson, & Lask, 2001; Neiderman, Zarody, Tattersall, & Lask, 2000).

Current Therapeutic Approaches

Inpatient treatments display a variety of therapeutic approaches, including dietetic (Mehler & Crews, 2001), pharmacological (Treasure & Schmidt, 2002), family therapies (Krusky, 2002), individual and group psychotherapies (Newton, Robinson, & Hartley, 1993; Gowers & Bryant-Waugh, 2004; Szmukler, Dare, & Treasure, 1998), specialised cognitive behavioural therapies (Pike, Loeb, Vitousek, 1996; Vitousek, Watson, Wilson, 1998), motivational enhancement (Ward et al., 1996; Vitousek et al., 1998) and multi-dimensional approaches (Lacey & Read, 1993; Garner, Garfinkel, Bemis, 1982; Beumont, Russell, Touyz, 1993). The therapeutic orientation underpinning eating disorder services currently tends to be

dominated by the cognitive-behaviour model⁷ (Striegel-Moore and Smolak, 2001). This approach presents an elaborated modification of behavioural approaches, which became popular in the 1960s (Bemis, 1978) since they offered the most cost-efficient method (2nd to pharmacological methods) by which weight could be gained within a limited period of time⁸ (6.18kg/month) (Agras & Kraemer, 1983).

Current Issues in Assessing Treatment.

Service protocols for treatment varies enormously across the world. In the UK, the current trend is towards a “‘stepped approach’, employing outpatient, day-patient and inpatient care in sequence” (Richards, 2003:350). Compromising this system are reports of poor co-ordination between these services and a lack of specialist units resulting in a shortage of service provision for those in critical need of care (Richards, 2003). The quality of service provision is also understood to vary considerably (NICE, 2004).

There is currently no conclusive evidence establishing a 'treatment of choice' for eating disorders nor consensus on best practice within ED literature (NICE, 2004). This has hindered the implementation of evidence-based treatment approaches in inpatient settings (Vandereycken, 2003). Furthermore, recent studies indicate that ‘non-specific’ supportive clinical management is superior to more specialised psychotherapies, which “challenges assumptions about the effective ingredients of successful treatments for anorexia nervosa” (McIntosh, Jordan, Carter, Luty, McKenzie, Bulik, Joyce, 2005).

⁷ The cognitive behavioural approach locates the core of AN psychopathology in obsessive concern with body shape and weight, which is understood to create dysfunctional dieting and other unhealthy weight control behaviours and is applied as a therapy through manualised cognitive and behavioural techniques to enhance motivation for change (Martin, 1985; Dare, Eisler, Russell, Treasure, Dodge, 2001; Gowers & Bryant-Waugh, 2004).

⁸ The behavioural method involves application of operant conditioning techniques, in which privileges are removed and returned as a reward for weight-gain to command patient compliance (Agras & Kraemer, 1983; Garfinkel, Kline, Stancer, 1973).

These issues and inconsistencies have generated a call for more systematic and standardised guidelines for clinical practice and treatment delivery (APA, 1992; NICE, 2004; Hoelsing, 2016). Obstructing this, considerable methodological difficulties persist in assessing treatments outcomes. The limited availability of patient participation in research is largely due to the high rate of patients ‘dropping out’ of treatment and patient reluctance to participate in research (Friedman, Ramirez, Murray, Anderson, Cusack, Boutelle, Kaye, 2016). Furthermore, the “variability within measurement procedures and design render most studies incomparable” (Stunkard & Stellar, 1984:205).

Treatment Efficacy and Outcomes

These challenges present a matter of pressing concern since it is widely acknowledged that inpatient treatment for AN continues to be largely unsuccessful, reflecting notoriously poor long-term outcomes (Bergh, Brodin, Lindberg, Södersten, 2002) and limited efficacy (Eckert, Halmi, Marchi, Grove, Crosby, 1995). Perhaps, Ben-Tovim (2003) suggests, no better than it was 50 years ago.

Reports indicate that 20 – 51% of patients ‘drop out’ of treatment prematurely (Eivors, Button, Warner, Turner, 2003; Button, Marshall, Shinkwin, Black, Palmer, 1997; Wallier, Vibert, Berthoz, Huas, Hubert, Godart, 2009), whilst patients often lose the weight gained in hospital shortly after discharge (Garner & Garfinkel, 1997) leading to repeated admissions (Broughtwood & Halse, 2008; Pike, 1998; Steinhousen, 2002). There are also considerable problems of chronic relapse (Deter & Herzog, 1994), of ‘recovered anorexics’ maintaining an acceptable weight but developing ‘bulimic’ symptomatology (Eckert et al., 1995; Eddy, Keel, Dorer, Delinsky, Franko, Herzog, 2002) and of weight-restored ‘anorexics’ and ‘bulimics’ continuing to experience psycho-social problems (Button &

Warren, 2001; Keel, Mitchell, Miller, Davis, Crow, 2000; Nilsson, Gillberg, Gillberg, Raastam, 1999; Pike, 1998; Steinhausen, 2002).

Symptom Prognosis and Perseverance

Research indicates that AN has the highest mortality rate of any psychiatric disorder (Smink, Van Hoeken, Hoek, 2012) in which 20% of sufferers will die prematurely from medical complications associated with the illness, a further 20% occurring through suicide (Arcelus, Mitchell, Wales, Nielsen, 2011; HSCIC, 2014). “In surviving patients, on average, full recovery was found in only 46.9% of the patients, while 33.5% improved, and 20.8% developed a chronic course of the disorder.” (Anorexia & Bulimia Care, n.d, para.13, citing Steinhausen, 2002; Papadopoulos, Ekblom, Brandt, Ekselius, 2009). Malson et al. (2011) identify that even these low recovery rates may well be over-estimated. Definitions of recovery remain controversial and vary between studies: those with more stringent criteria, covering a range of areas such as social and psychological functioning as well as body weight and eating tend to report lower recovery rates (Hardin, 2003).

Explanations for Treatment Failure

Within the current literature, poor treatment outcomes for eating disorders are largely attributed to individual factors (Mahon, 2000; Gremillion, 2003; Hepworth, 1999) and explained in terms of patients’ individual qualities (e.g. Holtkamp, Müller, Heussen, Remschmidt, Herpertz-Dahlmann, 2005; McIntosh et al, 2005; Tchanturia, Davies, Lopez, Schmidt, Wykes, 2008). Clinical characteristics such as weight on admission, diagnostic subtype and ED symptoms also dominate analysis accounting for premature discharge from inpatient treatment (Wallier et al., 2009). Comorbidities such as borderline personality, impulsivity, concurrent substance misuse and a history of obesity are also considered

predictors of poor treatment outcomes (NICE, 2004). The construction of AN pathology as inherently 'resistant to change' is also used to explain the difficulty in achieving treatment success and is based on the view that AN is a definitively ego-syntonic condition (Vitousek et al. 1998; Fairburn, Shafran, Cooper, 1999).

Inherent 'Resistance to Treatment' Reconsidered

Challenging this framework of understanding, Malson's (2004) study of patient perspectives found that 'resistance to treatment' was not an objection to treatment per se, but to the "particular de-personalised and un-individuated construction of 'the patient' as 'just [an] anorexic', devoid of (non-pathological) 'personality' and 'interests'" (p.482). From this perspective Malson (2004) states, "'resistance to treatment' might be interpreted as resistance to the particular power-relations implied in this construction of 'the patient'" (p.482). Similarly, Geller et al. (2001) conceives resistance as a relational product emerging between client and care provider rather than a trait that resides in the patient. Indeed, both Malson's (2004) and Eivor's (2003) studies found that 'feelings of powerlessness' within treatment were embedded in patients accounts of resisting treatment. Orbach (1978) proposes that patients' resistance to treatment may signify a protest of their position within society which is replicated within the hierarchy of the care team. Wright's (2010) review of the therapeutic relationship in inpatient contexts for AN concludes that "a better understanding of the reasons for the patient's resistance to treatment/therapy is [still] required" (p.159).

Treatment Focus on Food

Boughtwood & Halse's (2008) discourse analytic study found that resistance to treatment was informed by the construction of food within inpatient treatment. Food itself was seen to function simply as a 'medicine' and stripped of all other meanings, which resulted in a

clinical regime that “worked to perpetuate girls’ resistance to food” (p.278). Indeed, inpatient regimes that focus on food and weight have been widely criticised by both researchers and patients. Gremillion (2002), for instance, articulates how the strict and regulated focus on weight-gain characterising medical interventions for AN perpetuates the importance that food and eating already have in their life and for their identity, thus reinforcing the sufferer’s initial motivation to engage in these behaviours (also see Orbach, 1993; Eviors et al. 2003). Treatment focus on food has also been found to correspond to a lack of opportunity to address the issues underlying patients’ eating problems (Button and Warren, 2001; Tierney, 2008; Colton & Pistrang, 2004; Sesan, 1994; Malson et al., (2011), the neglect of which is understood to increase the likelihood of a ‘backlash’ in which girls will subsequently lose the weight they gained in hospital (Segal, 2003; Way, 1993), leading to the ‘revolving door syndrome’ (Wright, 2010).

Indeed, qualitative research has increasingly emphasised the importance of addressing the emotional and psychic aspects alongside wider psychosocial issues that necessitate ED behaviours (Bell, 2003; Malson et al., 2004; Malson & Ryan, 2008; NICE, 2004; Colton & Pistrang, 2004; Sesan, 1994; Federici & Kaplan, 2008; Long et al., 2012; Smith et al., 2016). Whilst these studies recognise the ‘re-feeding’ process within inpatient treatment serves an essential function to prevent further physical deterioration and death, it has been reported to be at the cost of other essential aspects of recovery (Trepal, Boie, Kress, 2012; Cockell, Zaitsoff, Geller, 2004).

The Therapeutic Relationship within the Inpatient Context

Increasingly, the role of relationship between patients and care providers is recognised to influence treatment success and patient recovery. Studies examining clinicians’ perspectives in particular have contributed to this literature with regard to inpatient contexts by identifying

the considerable interpersonal challenges of creating constructive relationships with patients. Such studies report the strong negative emotions of failure, helplessness, frustration, anger, competitiveness, revulsion and exhaustion that many healthcare workers feel when working with eating disordered patients (Garrett, 1991; Grothaus, 1998; Kaplan & Garfinkel, 1999; King & Turner, 2000; Ramjan, 2003; Ryan et al., 2006; Geller, 2001).

King & Turner's (2000) study of nurses' experiences of caring for adolescent anorexic females found that their core values of trust, honesty and being non-judgemental were lost and replaced by an inner turmoil of negative emotions, involving suspicion and distrust of patients. Nurses were found to label and stigmatise patients using derogatory terms, and develop a notion of 'us against them' over "who was going to 'win' the battle of protocol compliance" (p.143) and to employ metaphors of 'sabotage' and 'fighting' to describe their experiences. Ramjan's (2003) study of nurses in paediatric settings similarly reported that that nurses effectively became 'jailers who made [patients] eat, [and] administered punishment for not eating" (p.501). Ramjan found that nurses struggled to understand such a complex disorder, which led them to blame the patient for their illness, whilst nurses' feelings of frustration "made them sceptical and pessimistic about 'full' recovery. These findings support Jarman's (1997) conclusion that "subjective meanings and understandings are guiding the treatment process" (p.150). Herein, staffs' lack of understanding is identified to be an issue in treatment delivery that inhibits therapeutic relationships (Wright, 2010; Palmer, 2000).

Recommendation for Treatment Services

All the studies of clinician perspectives reviewed here emphasise the necessity for additional resourcing and training to facilitate the development and maintenance of positive therapeutic relationships with, and understanding of, these complex patients (Ryan et al, 2006; Long et

al. 2012; Ramjan, 2003; Jarman et al, 1997). Additionally, researchers have suggested that systematic features of treatment are undermining staffs' abilities to provide adequate care. Long et al. (2012) report, for instance, that staff lacked the opportunity to influence decisions and felt disempowered in their roles. Ramjan (2003) found that behaviour modification programmes were not conducive to the establishment of therapeutic relationships, concluding that to improve service provision "changes would be required in the way the hospital, as an institution, currently runs" (p.502). In King & Turner's (2000) study similarly, staff requested that care regimes and protocols incorporate new ways of thinking that enable the development of more genuinely therapeutic relationships. Breeze & Repper (1998) reported that nurses experienced pressure from the hospital system for patients 'quick recovery' and that "the hospital system as a whole needs to be more responsive to...the need for time to develop therapeutic relationships and not to 'move people on quickly" (p.1303), since this leads inevitably to their readmission.

To conclude, these researchers have expressed hope that their work will "lead to reconsideration of the approach to the treatment of eating disorders, a change which was called for over 15 years ago" (Mahon, 2010:211-212 citing Vandereycken and Pierloot, 1983). In light of this literature, I propose that research examining the influence of contextual features of treatment on patients' experiences could build on these studies to enhance current understandings of the interactional context occurring within inpatient services, identifying practices that enhance or obstruct the effectiveness⁹ of these services.

⁹ Effectiveness studies focus on the consumers' opinion of treatment effect, efficacy studies are defined by treatment outcomes according to clinician's opinion (Seligman, 1995).

Qualitative Studies on Patient Perspectives

Studies examining patients' perspectives provide valuable clinical insight regarding the qualities of treatment considered most important to patients. These include the desire to be treated as an individual person rather than defined by their AN diagnosis, and request a focus on psychological treatment not just weight restoration (Cockell et al., 2004; Malson et al., 2004; Button and Warren, 2001; Boughtwood & Halse, 2008; Cotton & Pistang, 2004). Issues of trust (Vandereycken & Devidt 2010) and feelings of powerlessness (Evors et al., 2003) have also been identified to influence patients' decision to 'drop-out' of treatment.

This research however has tended to examine populations or experiences outside of the inpatient context, examining factors affecting weight maintenance and recovery post-discharge (Cockell et al., 2004), non-attendance regarding appointments in outpatient services (Leavey et al., 2011), follow-up studies (Button & Warren (2001), the meanings of 'drop-out' (Evors et al., 2003; Vandereycken & Devidt, 2010) or focusing on specific treatment interventions such as inpatient mealtimes (Long et al., 2012) or cognitive remediation therapy (Whitney et al., 2008).

Only a handful of studies have examined patients' perspectives within inpatient settings and most have focused on adolescent populations (Tierney, 2008; Boughtwood & Halse, 2008; Cotton & Pistang, 2004; Van Ommen, Meerwijk, Kars, van Elburg, van Meijel, 2009). The studies existing on adult populations in inpatient settings include Smith's (2016) paper, which focuses on a single service setting and uses thematic analysis to illuminate patients' stages of change and transition according to levels of "perceived personal control" (p.16). Additionally, Pemberton & Fox's (2013) IPA/hybrid qualitative study examines the emotional management of inpatients and discusses patients' negative emotion towards staff and "high expectations of care" (p.235) in terms of typical characteristics in AN patients. The predominant focus of analysis within these studies is therefore centred upon patients'

psychological experience rather than the social conditions within treatment contexts informing these experiences.

Whilst discourse analytic research has focused on contextual factors and illuminated the issues arising from the use of medical discourses within inpatient treatment settings (Malson et al 2004, 2010; Boughtwood and Halse, 2008), patients accounts are examined in terms of their discursive implications informing the construction of patients subjectivities. There currently exists no study employing a ground-theory methodology that locates patients personal accounts at centre of the research enquiry and views them as a data source providing direct insight into the interactive context emerging within inpatient treatment delivery. Moreover, prior studies have tended to focus on a single treatment setting, rather than examine patients views and understandings gathered from experiencing multiple admissions within different treatment services.

This study seeks to contribute to knowledge of eating disorder treatment by addressing this gap in research. The use of a social constructionist grounded theory methodology will facilitate an in-depth exploration of participants' accounts of inpatient treatment experiences and help to elucidate the ways in which various features of a treatment context affect these experiences. This empirical focus aims to illuminate how inpatient treatment delivery informs patients' relationship with their eating disorder and their views of recovery.

Conclusion and Study Rationale

As reviewed, the potential for increasing treatment efficacy is considerable and improved treatment models are urgently required (Ben-Tovim, 2003; Wilson et al., 2007). Many studies point to the necessity of additional qualitative research to investigate the views and experiences of patients regarding their treatment to enrich and supplement the

information gathered by more standardised methods (Malson et al., 2011; Boughtwood & Halse, 2008; Vandereycken & Devidt, 2010) and to improve treatment effectiveness (Smith et al., 2016), the lack of which has been criticised as “neglect[ing] an invaluable source of information” (Colton & Pistrang, 2004:315). Patient’s dissatisfaction with treatment provision (Newton et al., 1993; Rosenvinge & Klusmeier, 2000; Yager, Landsverk, Edelstein, 1989; Ryan, Malson, Clarke, Anderson, Kohn, 2006), alongside the high risk of mortality associated to the condition, reinforce the proposition that research into patient’s perspectives is needed to improve eating disorder services (Mahon, 2000; Grilo & Mitchell, 2010).

Study Aims

The central aim of this thesis is to gain insight into patients experiences of in-patient treatment with the objective of improving current treatment provision for people suffering ‘acute’ or ‘enduring’ AN and of informing clinicians working in EDs about aspects of treatment that facilitate or hinder recovery. Gathering information from patients about treatment experiences answers calls for the development of new knowledge regarding AN both as a condition and how best to address it in inpatient contexts (see Burns, 2004; Eivors et al., 2003; Gremillion, 2003; Malson et al., 2004; Ramjan, 2004; Le Grange & Gelman, 1998; Mahon, 2000).

Counteracting the current research emphasis on outcomes as a measure of treatment success, a focus on the process of treatment delivery will generate insight into how current treatment strategies effect patients, as well as identify the relational dynamics that emerge throughout the treatment process. In response to gaps identified in the literature, this research will examine patients’ perspectives regarding their resistance or willingness to engage with treatment. In this way, the current study hopes to generate greater understanding of service-

user dissatisfaction (Malson et al., 2004; Grilo & Mitchell, 2010) as well as identify effective interventions and aspects of treatment that support patients' engagement with treatment and enhance their capacities for recovery. This study's qualitative methodology more broadly responds to statements emphasising the utility of qualitative methods to identify 'non-specific factors' in treatment (see Le Grange & Gelman, 1998; McIntosh et al, 2005) not revealed in quantitative research (Ryan et al., 2006).

The relational framework that distinguishes counselling psychology from clinical psychology or psychiatry underpins this research. Applying relationally orientated research and theory to an examination of ED treatment will contribute to other more traditional approaches to AN treatment and hopes to demonstrate the potential benefit of counselling psychologists within this field.

Chapter 3: Methodology

Identifying a research methodology involves a consideration of how best to examine the subject of my study. This study's objective to examine the psycho-social processes occurring within inpatient settings immediately narrows the possibility for an appropriate methodology, directing me towards a qualitative approach in which meanings concerning psycho-social phenomena can be explored. In discussing my methodological considerations and choices, I specify my underlying epistemological and ontological assumptions and consider how these sculpt my angle of enquiry. I shall further identify how I arrive at selecting a social constructionist grounded theory methodology.

Identifying my methodology

In determining an appropriate qualitative method for my research question, I considered several methods that are designed to examine how human beings experience and produce meaning. Interpretative Phenomenological Analysis (IPA), Discourse Analysis DA and GT all address this arena of human life and are commonly used in conducting qualitative psychological research. These methods bear great resemblance to each other in their approach to data collection techniques, interviewing strategies and analytical procedures. To decipher which of these methods would facilitate my research enquiry most suitably, I therefore examined their respective ontological and epistemological assumptions. This chapter thus begin with a brief description of the defining features of IPA and DA approaches and comparison to GT, which I ultimately select as my methodology of choice. I then discuss in further depth the principles of GT and detail the specific way in which I intend to use it.

Interpretative Phenomenological Analysis

Rooted in phenomenological philosophy, IPA assumes that the essence of an object or phenomenon can be discovered by penetrative examination of an individual's experience. In approaching data, researchers are required to 'bracket off' their own knowledge and preconceptions, as well as the object's location in a particular social context or institutional framework, with the purpose of identifying the essential characteristics of the phenomena, demonstrating thereby, a subjectivist epistemology and objectivist ontology.

Despite my interest in examining individual meanings, the focus of this study concerns the impact of contextual practices on individuals' experiences. The interactive, reciprocal processes occurring between individuals and groups thus demands a more intersubjective perspective than that which IPA could offer, since IPA does not attend to the intricacy of social processes that influence the individual's experience.

Discourse Analysis

Discourse Analysis investigates how language constitutes human subjectivity and society, proposing that "language both shapes and reflects dynamic cultural, social, and political practices" (Starks & Brown-Trinidad, 2007:1374). The DA researcher examines the association between language and human action, looking particularly at how the meanings of text represent a specific social and political practice within a particular society (Potter & Wetherell, 1987). I consider the way in which people use language to represent their experience of primary importance, viewing it as central in shaping how we understand ourselves, others and the world. Use of language therefore forms a central feature of analysis within this study and I shall consider how people's experiences and identities are inscribed within discourse. This study's dependence on text-based data to interrogate social phenomena further reifies the role of language in its capacity to reveal meaning and to reflect

group life. Furthermore, DA's constructionist and constructivist view of knowledge and meaning correspond to this study's interest in examining how meanings and persons are constituted socially and inter-subjectively. Additionally, DA's ability to provide insight into constructions of power that lie implicitly within discourse lends the method considerable critical capacity in critiquing social phenomena which this study will also aim to offer. These aspects of the DA method presented an effective means of analysing my research topic.

This study's additional interest to consider the experiential and constitutional impact of practices however, incorporates not only an investigation of discourse, but also the structural and behavioural elements of social production. This study will view language not only as a central means through which humans interpret, represent and reproduce their lived experience, but also as a symbolic tool by which humans to reach to identify the embodied, physical basis of human experience, contributing to - rather than fully constituting - materially lived experiences. Whilst DA focuses on the linguistic basis of social construction, this study investigates the practices which language describes.

DA's ontological foundations also reflect a definitively relativist notion of 'truth'. In its purest form, relativism contends that no reality exists beyond our subjectivity and that all truths are valid and relative. This study rejects this radical relativist ontology, contending instead that the inherent relationality and inter-subjectivity of 'truth' problematises the distinction between the subjective and objective positionalities, as I shall discuss in further depth below.

Furthermore, several excellent discourse analytic studies of this subject matter have been undertaken. In particular, Malson (1998) identifies discourses that elucidate both the perspectives of those delivering treatment and those being treated to identify the limitations of psychiatric discourse and practice, as well as providing a sociological examination of AN

as a contemporary phenomenon. This study seeks to build upon the knowledge developed in such studies by adopting a different methodology.

Grounded Theory

In contrast to IPA and DA, Grounded Theory (GT) examines how “social circumstances account for the interactions, behaviours and experiences of the people being studied” (Benoliel, 1996:413). In GT, this is achieved by studying the meanings people ascribe to experiences, actions and words. The method’s objective to explain how people behave, change, and interact in the context of specific situations centralises the study of relational and interactive processes as a means of understanding human behaviour, examining the reciprocal effects between individual and larger social processes. (Charmaz, 2006). GT is therefore recommended when investigating social problems or situations to which people must adapt (Corbin and Strauss, 2008; Schreiber, 2001; Benoliel, 1996). Moreover, its core purpose is to generate theory that is “grounded” in data, in the ambition to reflect the experiential realities of individuals (Goulding, 1999). This method therefore seemed ideally suited to this study’s objective to examine patients experiences of inpatient treatment with the view to illuminate the social processes occurring within these institutional contexts.

Since its inception during the 1960s, when GT was first developed, the method has seen several revisions, each adopting different epistemological and ontological assumptions. Below, I shall briefly discuss this development with the aim of specifying the version of GT I will be using. I shall then explore the influence of pragmatic philosophy and symbolic interactionist theory which constitute the epistemological roots of all GT approaches, and which help to identify the key principles, ethics and interests that lie within this study.

The Historical Development of GT

Developed initially by Glaser and Strauss (1966, 1967) within a scientific climate dominated by a positivist paradigm and quantitative methodologies, the GT method intended to challenge the wide-spread view that qualitative research methods lacked scientific rigour (McCann & Clark, 2003) by proving that sociological science could achieve a comparable standard of objectivity. As Glaser (2002) wrote ‘the carefulness of the GT method...makes the generated theory as objective as humanly possible’ (p.19). This was ensured by finding ways to eradicate the influence of ‘researcher bias’ arising within study findings. The method’s first inception therefore reflects the objective ontological assumptions of its time. Glaser’s academic roots in positivist science further informed his interest in developing abstracted models of social processes by identify underlying sociological structures. This lent him a particularly structural emphasis to the method, advocating GT as a means to discover generalisable, generic social processes.

Strauss’s loyalty to a symbolic interactionist perspective ultimately lead him to develop with Corbin an alternative GT method based on an interpretative epistemology and relativist ontology (Strauss & Corbin, 1994). Rejecting Glaser’s proposition that a researcher can achieve philosophical neutrality, their reformulation of GT re-asserted the importance of the specific-historical context within which all theories are embedded. Despite these philosophical underpinnings, Strauss and Corbin’s (1998a; 1990) method maintained the objective to minimise researcher ‘bias’ whilst ensuring researchers paid thorough attention to the broader contextual factors impacting on a situation. This was enabled by following a highly-structured data analysis procedure (Strauss and Corbin, 1998a; 1990).

Social-Constructionist Grounded Theory

The recent theoretical turn in qualitative research towards reflexivity and transparency has generated criticism towards Strauss and Corbin's method on the basis of their positivist rhetoric and critics contention that their data analysis scheme was "programmatic and over-formulaic" (Melia, 1996:370). Attending to this, a 3rd version of GT emerged (Charmaz, 2003) rooted in a definitively constructionist and constructivist epistemology (see Appendix 7 for a fuller discussion of this). Charmaz's constructivist grounded theory (SC-GT), like Strauss and Corbin, "places the interpretive understanding of subjects' meanings at the centre of the research endeavour and assumes the relativism of multiple social realities" (Charmaz, 2003:250). Differentially however, Charmaz explicitly rejects the 'objective assumptions' declared by Glaser, and implied by Strauss and Corbin in seeking to eradicate 'bias' from the analytic process. By applying the symbolic interactionist view of knowledge and meaning to its methodological conclusion, SC-GT locates researcher 'bias' as an inevitable influence, since the theory that 'emerges' consists of the researcher's interpretation as well as the research participants. Charmaz therefore emphasised the transactional nature between participant and researcher by which data is produced (Fassinger, 2005) insisting that researchers recognise their active, creative role in constructing meaning and theory from participants' accounts (Levers, 2013).

Charmaz (2006) subsequently proposes that each stage of inquiry is influenced by the researcher's assumptions, interactions and unique interpretations, and that study results necessarily incorporate both the participants' and researcher's views. To moderate the researcher's influence on the analysis process, the SC-GT method places particular emphasis on faithfully representing the views and realities of the participants. The SC-GT researcher therefore makes every effort to identify the meanings attached to actions and objects as the participants themselves understand them.

My own experience of being an inpatient is therefore understood to inevitably inform and influence the analysis process. On the one hand, such personal experience enables me to take an 'insider perspective' which is explicitly reached towards in SC-GT as it is seen as a way of gaining closer ground with participants' realities. Counteracting this personal influence, my dedication to representing the views and experiences of participants is supported in the 'in vivo'-coding, memo-writing and the persistently close relationship I maintained with participants' data throughout the analysis process.

A SC-GT study does not assume overarching applicability (Mills et al., 2006), but presents one way of describing and explaining the social processes for those particular participants, as situated within a particular time and culture. Nevertheless, whilst SC-GT rejects Glaser and Strauss's use of GT to discover essential underlying social processes, GT analysis actively examines the commonalities between participant perspectives to indicate a viable and useful conceptualisation of the data, which can accommodate considerable individual variation within a common social context. The SC-GT study therefore works towards theoretically conceptual rather than solely descriptive presentation of categories, although Charmaz emphasises that generality emerges "from the analytic process rather than as a prescribed goal for it" (Charmaz, 2006:181).

In these ways, Charmaz's re-formulation of GT helps to strengthen its methodological foundation within the principles and perspectives advocated by symbolic interactionism and pragmatism. This serves to overcome prior criticisms of the GT method, which has been widely accused of methodological weakness and ambiguity (MacDonald & Schreiber, 2001). On the basis of these methodological considerations, SC-GT was found to most accurately represent my own epistemological assumptions and beliefs, and presented the most compatible method to meet this study's aims and objectives on premises I shall discuss in further depth below.

A Pragmatic Ontology and Relational Epistemology

In accordance with SC-GT, the claims upon reality and knowledge this study generates is informed by pragmatic philosophy, which underpins the theoretical approach of symbolic interactionism (Mead, 1934) and coheres with the principles of social constructionism (Gergen, 1999; Charmaz, 2003). Contrary to positivists, who hold that objects determine experience, and relativists, who hold that subjects determine experience, pragmatists breaks down the traditional distinction between object and subject, asserting that both objectivism and relativism rely on an abstract separation of subject and object (Rochberg-Halton, 1986). Understanding experience as “an affair of the intercourse of a living being with its physical and social environment” (Marks 1992:165), pragmatists propose that object and subject determine each other in a mutual, relational, reciprocal process of reality production (Gergen, 1999; Goffman, 1978; Totton, 2016).

Defining Reality

SC-GT asserts that reality is constructed by individuals as they assign meaning to the world around them (Appleton & King 2002): meaning does not lie dormant within objects waiting to be discovered, but is rather created as individuals interact with and interpret these objects (Crotty, 1998). Like social constructionists (SC's) and symbolic interactionists (SI's), pragmatists contend that reality is not reflected in nature, but is socially derived in the meanings produced through interaction. Reality is therefore “nowhere else but in active experience, i.e. in action” (Strübing: 2007:5)

Whilst considering many accounts of reality to be possible, depending upon whose standpoint is taken (Mead, 1934) such accounts generate theories *about* reality, rather than factual, unquestionable representations *of* reality. This position does not object to a reality outside of perception (realism), but rather to the claim that ‘truth’ about that reality can be

accurately measured and defined through the use of hypothetico-deductive scientific research methods (Crotty, 1998). Accordingly, this study aims not to identify the reality of objects, but to examine the meanings humans ascribe to phenomena, regardless of whether they be materially or socially manifest.

Drawing on Berger and Luckmann's (1991) classical variant of social constructionism, this study centres upon the intersubjective construction of processes and outcomes, where socially defined and negotiated realities are central. Within this, Berger and Luckmann's conception of language as a sign system is incorporated. They explain:

language's ability to objectify abstract spheres of meaning enables society to augment both objective reality by way of institutionalization and legitimization, and subjective reality, through socialization and the development of identity, and that these two domains of reality constitute and are inextricably bound up in the discursive fabric of social meanings.
(Hruby 2001:53, citing Berger and Luckman, 1991)

According to this philosophy, 'reality' is constituted by the linguistic and discursive conventions we appropriate. These "descriptive languages are not derived from observation; but operate as the lenses or filters through which we determine what 'counts as an object'" (Stam, Rogers, Gergen, 1987:2). As W. I. Thomas's famously stated: "when people define situations as real they become real in their consequences" (cited in Plummer, 2000, para. 19). Thus the meaning of ideas are evaluated in terms of their practical application to, and impact on, lived experience. This involves studying the meaning and assessing the value of ideas in terms of their "conceivable practical consequences" (Marks, 1992:164). In contrast to post-modernism, where language replaces activity, pragmatisms linkage of meaning to action

points to the centrality of experience in realising the mode of being projected by discourse. By considering meaning to be derived through associations between symbols and actions we have the basis of a principally relational argument (Gergen, 1999)

Reifying the materiality of human experience, language within this study is viewed as inseparable from our embodiment (Merleau-Ponty, 1962, 1968) and contends that experience is symbolised between body and mind in a reciprocal, non-linear relationship. The mind therefore is understood as one part of the body through which we perceive and experience the world we are in. It is through our bodies, as much as through language, that we generate individual and collective ‘realities’ and perpetuate these realities interpersonally, institutionally and culturally through inter-action involving both explicit and implicit communication and interpretation processes.

Understanding Human Behaviour: Constructing Meaning Through Social Interaction

In seeking to understand human behaviour, symbolic interactionists propose that people respond (or act) on the basis of their interpreted meaning of those objects and actions (Blumer, 1962; Charon, 1979; Meltzer, 1972). The symbolic interactionist, Mead (1934) concludes, must always seek to understand the causes of action, the consequences of action, the perception of our own action and the perception of other people’s action. Furthermore, meanings are understood to be constantly being built and re-built through interaction with others (Blumer, 1962; Flick, 2013).

Symbolic interactionism illuminates how the very notion of ‘the individual’ is constructed through interaction and relation with the other, viewing interaction as the central means through which individual subjectivities, cultures and societies are constituted. Similar to social constructionism, symbolic interactionism sees the individual's social world as a vast continuous process, in which the meanings of objects are socially formed, sustained and

transformed through group interactions. Upholding these principles, SC-GT assumes that interaction is inherently dynamic and interpretative, and is concerned with how meanings and actions are created, enacted, and transformed in the social world between people. As Gergen (2009) states “It is not individual minds who come together to form relationships; it is out of relationship that individual functioning emerges” (inside cover).

The social constructionist perspective however does not assume individual or collective volition in the constructions that people are part of producing, but are involved, unintentionality and unpredictably in the outcomes generated by particular constructions. As Berger (1963) wrote:

Our bondage to society is not so much established by conquest as by collusion... The walls of our imprisonment were there before we appeared on the scene, but they are ever rebuilt by ourselves. We are betrayed into captivity with our own cooperation. (p.121).

A concept of Self and Identity

Alongside pragmatism's view of self as process, a person's 'self' is identified as any reflexive object of a person's consciousness (Denzin, 1987): by making ourselves the object of our actions (and thought) we create and perpetuate the notion of self (Weigert & Gecas, 2003). Differentially, identity is understood to be a social location that establishes who a person is in a pattern of situated interaction (Alexander & Wiley, 1981; Foote, 1951; Gecas & Burke, 1995; Stryker, 1980; Travisano, 1993). Whilst the “self is comprised from diverse parts” (Stryker 1968:559) and constituted by multiple identities (Abes, Jones, McEwen, 2007), identities are viewed as meaning dimensions for the self (Stryker & Burke, 2000). “Identity is [therefore] a social production, not an individual property” (Atheide, 2000:3).

SC-GT thus contends that the "self is fundamentally social in nature [because it] is developed and maintained through social relations" (Charmaz, 1983:170). The symbolic interactionist perspective further argues that a person sees or defines themselves according to the way in which others see and define them, and in doing so, the person becomes an object and is able to engage in social 'role-taking' (Mead, 1934). This study draws on this framework by examining the 'role-taking' processes within the context of inpatient treatment to explore how interactional forces shape individual identities and potentialities.

Centralising the Participant's Perspective

As mentioned, a defining feature of SC-GT concerns the researcher's objective to give voice to participants' perspectives and experiences. By taking the viewpoint of those studied, the researcher aims for a deep understanding of those individuals' realities (Crotty, 1998). In honour of this, Charmaz (2003) suggests that, rather than look for one main concern, grounded theorists should seek to construct a "picture that draws from, reassembles, and renders subjects' lives" (p.270).

In using this method therefore, I seek to understand behaviour as the participants themselves understand it, learning about their view of the world and sharing their definitions (Baker, Wuest, Stern, 1992:1357). These values support an empathic understanding of participants' stories from the researcher and a compassionate insight into what is being observed (Moustakas, 1990). This perspective resonates with Counselling Psychology's core relational and pluralistic principles (Division of Counselling Psychology, 2005) which emphasise the ethics of recognition in clinical practice. This involves a dedication to respect first person accounts as valid in their own terms; "to negotiate diverse perceptions and world views without assuming the automatic superiority of any one way of experiencing, feeling,

valuing and knowing" (Mooney, 2014:48), "to recognise discrimination and aim to empower rather than control" (Division of Counselling Psychology, 2005:2).

Ethics

Pragmatism's focus on consequences acknowledges how the very acts of researching and theorising are engulfed in ethical and political matters. By cohering philosophy with a social purpose, pragmatism effects "normative meaning and moral force" (Kadlec, 2006:573). As Plummer (2000) states: "If there is such a thing as an ethics-free research or a politically neutral theory, it will be a strangely inconsequential thing" (p.18). Indeed, this study's refrain from identifying with postmodernism is informed by its potential to effect moral relativism by reducing human experience to a subjective opinion, collapsing reality into representation and lending itself to an a-moral, a-political perspective (Chomsky, 2008). "For Dewey, if we do not undertake a pragmatic reconstruction of philosophy aimed at recovering lived experience as a socially dynamic reservoir for critical reflection we will be unable to understand, much less expose, systemic patterns of injustice and inequality plaguing our past, present, and foreseeable future" (Kadlec 2006:540).

This study draws on the ethical and emancipatory utility of this philosophical framework to examine the consequences arising through social processes occurring within residential treatment settings for AN. This study seeks to formulate a useful, common-sense conceptualisation of social phenomena, with the purpose of providing insight into a field currently struggling to benefit the people for whom it is designed to help. Moreover, Fassinger (2005) states, "GT integrates theory and practice in ways that few other approaches can boast, constituting a methodological exemplar of the scientist-practitioner model" (p.165). He further argues that when integrated with a "critical paradigm focused on oppression and power, this method comes closer than any other approach—quantitative or

qualitative—to exemplifying a science-practice-advocacy model of professionalism in counselling psychology” (Fassinger, 2005:165, 2000, 2001; Fassinger & O’Brien, 2000).

Validity and Reliability

In approaching research as a co-constructive process, it is understood to be inevitable that a different researcher would, using the same data, interpret, pursue and develop different meanings from those that I produce. To support a study’s validity therefore, Charmaz (2006) encourages the researcher to make explicit their personal and professional objectives in undertaking the research. Charmaz (2014) also builds on Glaser’s (1978) criteria for the evaluation of a grounded theory according to fit, utility, relevance and modifiability by adding the criteria of credibility, originality, resonance, aesthetic merit and analytic impact, as well as centralising the role of reflexivity and transparency in the process of theory production.

Chapter 4 Method

This chapter describes the method by which I collected and analysed data for this study. In seeking to make this process transparent, I describe how I went about recruiting and interviewing participants and detail the analytic procedure by which I arrive at a substantive theory.

Choosing Interview as a Means of Data Collection.

Gathering data by means of interview is widely used in GT as it “facilitates an open-ended, in-depth exploration of an area in which the interviewee has substantial experience” (Charmaz, 2014:85). The semi-structured interview method in particular enables the researcher to focus the topic while providing the interactive space and time to enable the participant’s views and insights to emerge spontaneously (Charmaz, 2014).

Whilst developing a grounded theory is understood to be complemented by analysing multiple types of data, such as “observations, surveys, focus group interviews and...written accounts” (Charmaz, 2014:85), the limited size of this project indicated that information generated from interviews would provide ample analytic material. The scope of this study was further focused by exclusively interviewing patients as an avenue through which to develop understanding of the social processes occurring within inpatient contexts.

During interview, I elicited participants’ stories, primarily exploring how they experienced inpatient admissions treating an AN diagnosis. The sample size of between 8 and 12 participants was based on both on the aim to achieve theoretical saturation (Mason, 2010) and the practical limitations of the researcher, as guided by other similar GT studies.

Data Recording and Protection

Interviews were digitally recorded and transcribed by the researcher. All names, places and other potentially identifying information were blanked in the transcript and participants were given a pseudonym. Transcripts and audio files were stored within password-protected files on my private computer and labelled with an anonymous code. In writing the analysis I provided participants with pseudonyms that corresponded to their position in the sequence of interviews with P.1=A(Anna), P.2=B(Becky), P.3=C(Cathy) and so on.

Sampling Methods and Recruitment

To initiate recruiting participants, my first three interviews were acquired through a snowball sampling process (Atkinson and Flint, 2001), identifying cases from “people who know people who know people” (p. 182) who are information-rich. These interviews were undertaken at a mutually agreed time and place and lasted between a 1.5 and 2 hours.

Thereafter however, I applied a method of convenience sampling to gain access to further participants, as gaining access to the target population proved challenging. Convenience sampling proceeds by way of locating any convenient cases who meet the required criteria (see Appendix 11) and then selecting those who respond on a first-come-first-served basis until the sample size quotient is full (Robinson, 2014). This method of convenience sampling provided information-rich data, since the participants interviewed tended to have extensive experience of inpatient environments owing to long admission periods and/or familiarity with multiple clinical institutions (see Appendix 14).

I sent an email to several inpatient eating disorder services and organisations containing a brief description of the research project in request of support to disseminate information inviting participation in the research (see Appendix 8). Two clinics expressed interest to facilitate my research, actively offering support by inviting me to undertake

interviews at the clinic in a private space at a specific date and time, allowing for 1 hour with each participant. The service managers of these services conceded to advertising my poster (see Appendix 9) and to disseminate an information document (see Appendix 10) to generate further interest in the study. Both these clinics were familiar with my work in eating disorder recovery and had previously employed me on a voluntary or free-lance basis to provide additional recovery services for their patients/ex-patients.

One clinic, located in West London, was a privately funded residential addictions service, adopting a 12-step approach to recovery and provided treatment for a wide range of addiction issues including eating disorders. At this location two participants (P.4-Daniele and P.5-Emily) came forward for interview.

The second clinic, a 10-bed residential centre in Norwich specialised in eating disorders only. This service identified with a person-centred approach to treatment and recovery, depending on funds from a combination of local government, private insurance and private sources. At this location six participants came forward for interview (P.6-Fiona, P.7-Gina, P.8-Helen, P.9-Iris, P.10-Julie, P.11-Karen). Owing to the distance of the service from my living location and the organisational demands on the service of the interviewing process, I undertook these 6 interviews on the same day. Whilst this is not advised in GT methodology as it inhibits the possibility of sensitising analytic concepts following each interview (Charmaz, 2006), I made concerted efforts during the day to follow up on topics arising in preceding interviews as a means to capture and expand on immediately apparent or central themes that were emerging within interview.

Interviews were precipitated by an inclusion criteria checklist (see Appendix 11), were invited to complete a demographic and history generating questionnaire (see Appendix 12), and sign a consent form (see Appendix 13) informing participants about confidentiality, anonymity, data storage, and their right to withdraw from the study.

Inclusion Criteria and Demographic Profile

Participants were selected on the basis of having undergone in-patient treatment for a minimum of one month within the past 4 years. This 4-year remit was chosen to ensure that their experience was still relevant to current clinical practice. Inpatients, outpatient or ex-patients were permitted to participate. All study participants were either current inpatients or had been discharged within the previous 4 months. All participants had experienced a considerable amount of time within the inpatient context, ranging between 6 months and several years. Experiences of child and adolescent units were sometimes discussed during interview alongside experiences of adult services. People who were actively suicidal or psychotic were excluded from participation. Participants ages ranged between 18 and 56. First diagnoses of AN occurred during adolescence or their early 20s in all participants. Seven participants received a restricting type AN diagnosis. The remaining four participants reported a binge-eating/purging type AN diagnosis. All participants were British and had been raised in England, most White Caucasian. One participant was of British-Chinese heritage, another of British-Turkish heritage. Participants came from a range of socio-economic backgrounds and different cultural environments within England. The Demographic Graph (see Appendix 14) further details patients' demographics and historical information regarding inpatient experience.

Ethical Considerations

Ethical approval was gained from the University of Roehampton's Ethics Committee prior to participant recruitment. Herein, some essential ethical issues were addressed. Aware that the study's interview questions may bring up painful emotions for participants (Shaw, 2003), and owing to the vulnerability of patients both physiologically and psychologically, each

interview taking place within inpatient settings were individually authorised by the clinical lead and management team. It was explicitly discussed and agreed that if material arose from interview requiring further support, a staff member within the inpatient context would be available to attend to the patient. At the beginning of each interview I discussed this openly, making sure participants were informed about this additional support should they want it, as well as reminding them of their right not to answer questions and encouraging them to take their time and allow for breaks during the interview process.

Where interviews took place outside of a clinical context, participants were also given a debriefing sheet (see Appendix 15) containing contact details for support services local to them should they wish to obtain further support following the interview. On conclusion of the interview I allowed time for debriefing from the interview process, made sure they felt ok about the experience and information shared, and invited them to contact me at any point if further questions or concerns were arising. I also ensured participants had identified the most suited source of support if challenging feelings arose following the interview process. In these circumstances, I followed the University's Lone Worker Policy by arranging to contact a member of my immediate family before and immediately after each off-site interview.

The Interview

Constructivist Grounded Theory explicitly acknowledges the researcher's own experience and perspective in the research process, viewing the interview data as a product interactively and inter-subjectively created between participant and researcher. To develop a trusting rapport in which participants felt informed about the study intention and comfortable with me personally, I explained my central research intention - to represent and validate the patients voice within clinical literature on treatment for eating disorders. I explained that I believed

this was a crucially important, but currently deficient, source of information that could help to improve service provision.

Negotiating Power and Disclosure

Integral to my ethic as a Counselling Psychologist and the emancipatory objective of the research is the attention given to power imbalances that inevitably occur between interviewee and interviewer, patient and clinician. Additionally, I was aware of the distrust and sense of disempowerment that patients sometimes feel when being questioned by clinicians and medical professionals about personal issues. To dissolve this potential barrier and to address this disparity of power that existed in our respective roles, I decided to disclose to participants that, whilst I was now working in the field of eating disorders, I had once been an inpatient myself. Whilst I did not want to compromise the interview material, this disclosure felt valuable, if not necessary in several ways.

Three participants came forward for interview at the last minute in one clinic on account of finding out that I had been through inpatient treatment and recovery for an AN diagnosis myself. They communicated how this information helped them to trust my research intention of giving voice to their experiences, dispelling their fear or preconception that the study would be intrusive and position them as clinical subjects. Several more participants similarly stated that my positioning as an ex-patient helped to verify my stated intention of representing their voice as patients. These disclosures strongly indicated the sense of trust my disclosure enabled in participants.

Although I did not disclose any information about my treatment experiences, this piece of personal information is likely to have influenced the material participants chose to share during interview and inform the way they shared it. My felt impression was that it helped participants to have faith that I held a fundamental attitude of compassion towards the

endurance and struggle involved in undergoing treatment and recovery. In considering me as an 'insider' (Dwyer & Buckle, 2009) participants seemed to feel more free to express their feelings about the institutions in which they had received treatment, indicating a foundation of trust within the interactional context of interview advocated by Charmaz (2000) and others (Hannabuss, 1996; Mellon, 1990). On the other hand, I was aware that participants' assumptions about my experiences, be they positive or negative, may have influenced their narrative. I therefore made every effort to elicit a range of experiences covering positive, negative and ambivalent feelings and to be equally receptive to all types of experiences and feelings.

I was also aware of the potential influence of undertaking interviews within the clinical context itself, since it risked compromising their ability to speak freely about the service in which they were located. I therefore reiterated to participants' the full confidentiality of their accounts, explicitly stating that all information would be anonymised in name and source to reduce fears that any controversial information, including criticisms of the service in which participants were being currently held, would remain anonymous and therefore unidentifiable.

Interview Protocol

The semi-structured interview format was chosen to allow participants to reflect spontaneously on specific areas of their experience whilst permitting the researcher to intervene with questions or prompts as a guide (Birks & Mills, 2011) should the conversation deviate away from the research interest (see Appendix 16 for Interview Question Outline).

Interview began with the question: "What made you decide to participate in this study?" Participants' responses tended to highlight their desire to improve eating disorder treatment and their appreciation for the opportunity to have their voice heard and represented.

As an entry question, I often asked participants about the circumstances by which they came to be diagnosed and first came into contact with eating disorder services. This preamble generated interesting information regarding many participants experience of how the eating disorder emerged and subsequently began to ‘spiral out of control’ before they were admitted to some form of inpatient care. This produced material about the meanings and purpose of participants eating disorder during its early stage of development and how this changed. Such information, whilst not included in my final analysis, was hugely enriching by gathering a picture of contextual factors that exacerbated the illness. It illuminated, for instance, how the ‘ED’¹⁰ was triggered and deepened by the experience of having no control in their life and feeling isolated. This provided greater meaning to data detailing participants negative response to treatment contexts where, for instance, patients felt denied a sense autonomy or felt unable to connect with staff. Participants adverse responses to contexts in which they felt disempowered engendered feelings that tended to reinforce eating disorder thoughts and to generate a greater sense of reliance on their eating disorder (ED) to cope with the inpatient environment.

Following this preamble, I then invited participants to reflect on their treatment experiences with non-specific questions such as: “Would you like to tell me about your experience of in-patient treatment? This broad approach to enquiry follows a method that aims to gather data with minimal direction or pre-conceptual imposition from the researcher. This supported the methodological commitment to ensure that findings are ‘grounded’ in the meanings emerging from participants lived experience, as opposed to responses shaped by concepts and issues pre-conceived by the researcher. Despite this refrain, I made sure that several areas of interest highlighted by the literature review were covered within interview. These included reflections, where relevant, upon:

¹⁰ ‘ED’ represents the term common appropriated by participants to describe the eating disorder entity.

- Inpatient treatment – what kind of treatment they experienced and what it was like
- How they negotiated treatment demands
- Experience of relationship with staff

Data Analysis

The SC-GT method develops theory through an iterative process of data analysis involving coding, conceptualising, diagramming, memo-writing, constant comparison, theorising, and examination for new or contending data. These processes occur alongside data collection and reach towards a point of ‘saturation’ whereby no new themes, categories or relationships are found in the data (Fassinger, 2005) (see Appendix 17 for extended discussion on theoretical saturation). Immersing myself in the data, transcripts were listened to, read and re-read numerous times. Returning to the raw data throughout the analytic process enabled me to maintain my relationship to the contextual meaning of analytic codes, as well as to ensure that the coding process was grounded in participants own language (Charmaz, 2006) and reflecting the meanings I understood participants to be expressing.

Theoretical Sampling and Interview Evolution

Theoretical Sampling is a pivotal strategy in grounded theory methodology (Charmaz, 2000) referring to the process by which to gather rich data, develop theoretical categories during the data collection stage, and to discover variations and gaps within or across emerging categories. Glaser and Strauss (1967) indicated that theoretical sampling occurs when “the analyst jointly collects, codes, and analyses his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges” (p.45). This study engaged in theoretical sampling by beginning data analysis immediately following the first

interview¹¹. Ample time was provided between the first 5 interviews to undertake analysis alongside the gathering of this data. I therefore began to identify codes and tentative categories early on in the data collection process. Engaging in analysis alongside data collection enabled me to adjust and focus interview questions to expand understanding on recurring patterns emerging in the data and to generate richer information on categories that seem relevant to the emerging theory (Charmaz, 2014; Draucker, 2007). In this way interviews were modified to test and expand emerging theoretical concepts and to test for variation within a concept (as recommended by Milliken & Northcott, 2003). Identifying the theme of ‘control’ from analysis of the second interview for instance, I integrated a question about participants views on control into the interview procedure. Following the third interview I identified that distinguishing between person and illness was being reported as a particularly constructive approach in treatment. I therefore asked subsequent participants to discuss this point and to reflect on its relevance to them. Data collection, in this way, was progressively focused and informed by the evolving theory.

Coding and Categorisation

Analysis began by coding the collected data, which served to break down the transcript into units of meaning. I adopted a line-by-line coding method for the first three interviews (see Appendix 18 for example), as a way of ensuring I remain maximally open to the multiplicity of meanings within the data during the early stages of analysis and to minimise the possibility of subjective distortions arising from any personal motives or opinions that I, as a researcher, may have been bringing to my transcript readings and interpretations (Charmaz, 2003).

¹¹ This method is referred to as constant comparison analysis which identifies the process by which to collect and analyze data simultaneously

Thereafter, coding was applied to data samples, ranging in size from a word to a paragraph. These initial codes, tended to be descriptive and identify “actions and processes” (Charmaz, 2006:69). They were compared, sorted and interrogated for alternative interpretations. Identifying gaps in the coded data helped to generate further questions to direct the research enquiry forward. These initial codes were organised through selection and synthesis into focused codes (see Appendix 19 for example), which raised the conceptual level of analysis (Charmaz, 2006) and gave rise to tentative categories (see Appendix 20). Theoretical codes were identified through comparing and synthesising focused codes, giving form to the relationships between categories and cohering focused codes into broader analytical frameworks (Charmaz, 2006; Glaser, 1992). Theoretical coding helped to identify the specific conditions and contexts in which actions, processes and consequences occurred (Holton, 2007; Birks & Mills, 2011; Charmaz, 2006). Through a method of constant comparison, new data was integrated into the emerging theory to generate coherent categories of meaning (see Appendix 21 of early saturation process).

In labelling categories and codes, ‘in vivo’ codes helped to preserve the voice of participants, which articulated concepts with more incisive meaning and specificity, whilst providing another means by which the developing theory remained grounded in the data (Charmaz, 2006).

Continual memo-writing and clustering techniques assisted this process of theoretical development. An essential method in SC-GT, memo-writing encourages the researcher to begin analysing data from the earliest stages of the research process (Glaser, 1998). Initially helping to identify important codes, memo-writing helped in later stages of the analytic process to identify both properties and patterns within and between the categories (Charmaz, 2006; Glaser & Strauss, 1970). Simultaneously, ‘clustering’ methods were used to map out the codes, categories and properties, in a visual, flexible and non-linear form. This provided

an effective and creative method for clarifying the categorical relationships, re-organising and developing deeper understanding of the data (Charmaz, 2006). The iterative nature of this process encouraged me to elaborate codes and reconsider categorisation throughout the analytic process, checking continuously its source validity. For a diagrammatic overview of the analysis process see Appendix 22.

Research Validity

To ensure the validity of this research, I followed Yardley's (2000) widely supported guidelines and procedures for enhancing, evaluating, and demonstrating the quality of qualitative research (Cohen & Crabtree, 2008). These measures are grouped broadly into four key dimensions including: sensitivity to context; commitment and rigor; transparency and coherence; and impact and importance (Yardley, 2000; Yardley, 2008).

I demonstrated sensitivity to context during the data collection process by explicitly acknowledging with participants the potential impingement on interview participation caused by undertaking interviews whilst admitted within a clinical context they may wish to discuss. This issue or conflict of interest for participants was mitigated by highlighting the confidentiality procedures in place that would adequately protect any sensitive or compromising information shared about the clinic in which they were currently situated.

In awareness of the sociocultural and linguistic context of the research, I have acknowledged how my own socio-educational and personal history is likely to have influenced both the analytic process and the language by which I have named and articulated theoretical categories (see sections 'Methodological Reflections' p.68, and 'Context Specific', p.172).

Regarding validity of the data analysis process, I fulfilled the criteria of commitment and rigor by demonstrating my sensitivity to the data in carefully considering the meanings

generated by the participants and making sure I did not impose pre-conceived categories on the data. This was achieved by reviewing my analysis through repeatedly returning to the raw data to check for accuracy of representation and retracing the process of analytical development more than three times at different stages of the research process to check that the resulting theory accurately and adequately represented participants accounts and was therefore 'true' to their voices of experience. Transparency of this analytic process has been aimed at by presenting sections of coding, focused coding and tentative category development in Appendices 17, 18 and 19. In the write-up of the analysis, I ensured a detailed and in-depth analysis by integrating relevant literature to substantiate the validity of my findings (see Chapter 5, Data Analysis). Furthermore, the importance of the findings has been discussed in some detail both in the analysis and discussion chapters detailing how these findings highlight current and clinically relevant issues, as well as effective ways of working in the clinical context, that bear directly on the outcome of treatment for patients suffering and recovering from severe and life threatening eating disorders.

Methodological Reflections

Resonant with a constructionist approach, the emerging (and final) theory is understood to be the product of an on-going interaction between the researcher and the data (Charmaz, 2008). Quite simply, development of codes and categories requires interpretation and conceptual choices (Charmaz, 1995). My reading of the data reflects the issues that seem to be most salient and compelling in my view. My choice of conceptual terms to articulate phenomenon and category labels inevitably draw from my own conceptual framework of understanding, which is influenced by both my professional background in Counselling Psychology, which is rooted in a relational view of psycho-social phenomena, and my personal experience, that understands the internal conflict involved in suffering from an eating disorder. Another

researcher may question, interview, analyse and organise concepts differently, resulting in a different theoretical portrait of the data.

This study further acknowledges that participants' narratives of their treatment experience were necessarily selective owing to factors including their own motivation to partake in the research, their interpretation of the researcher's objective and interest, the time and spatial constraints of the interview setting and the effects of selective memory processes. The grounded theory emerging from this study therefore presents a partial rather than total representation of participants experiences of treatment.

Additionally, analysis might appear awkward since it develops from a heuristic sequence of interpretation. My interpretation of patients reflects their interpretation of staff's attitudes. The study is concerned with treatment staff's views but are not themselves staff's accounts. Indeed, it is possible that staff would represent their own views of patients and experiences of the inpatient context quite differently. The 'reality' I present in my analysis is therefore putative since it presents an interpretative rather than direct study of social phenomena occurring within the treatment context. This study's methodological location in the interactional nature and production of reality however reifies the reality constructed by patients as real to them and therefore valid for empirical enquiry. I also believe that since treatments purport to be of service to patients and their wellbeing, patients accounts reporting on this service are central, not peripheral.

One might further question whether participants' descriptions of their treatment were 'accurate'. My impression was that the participants spoke openly and honestly in the interviews. However, GT's interest in interpretation regards the individual's perspective as central in illuminating the meanings that are relationally produced within a social context. Therefore, matters of objective 'accuracy' play little if any role in the production of a theory. Furthermore, the method takes a relatively 'naïve' view of discourse, by comparison to a

discourse analytic method for example: GT's objective to 'give voice' to participants demands an analytic perspective that assumes a participant's account reaches towards 'real' experiences.

The reality I have depicted within this study also presents a one-sided portrait of the relational field emerging within inpatient treatment contexts. Despite the perspectival imbalance of gathering data from the patients' but not staffs' perspective, this nevertheless helps to redress the corresponding imbalance in current research that is predominantly reflective of clinicians' or observers' perspectives. It therefore it raises the visibility of patients' experiences whilst validating patients views of treatment as a key source of information by which to identify how practices are serving or failing patients within these contexts.

Summary

This chapter has outlined my method of analysis as a means of achieving my research aims. It articulates the steps undertaken, accompanied by diagrammatic representations to make explicit my analytic process and concludes with methodological reflections. The following chapter presents the research findings.

Chapter 5: Data Analysis Results

The overarching category that emerged is titled ‘Fighting for survival’, which encapsulates the central findings of two divergent psycho-social processes identified in patients’ responses to residential treatment. These are represented in two main findings: 1) *The Feeding Clinic: Embedding Anorexia* (category A) and 2) *Empowering the person: Fighting the ED* (category B) as presented in Figure 1.

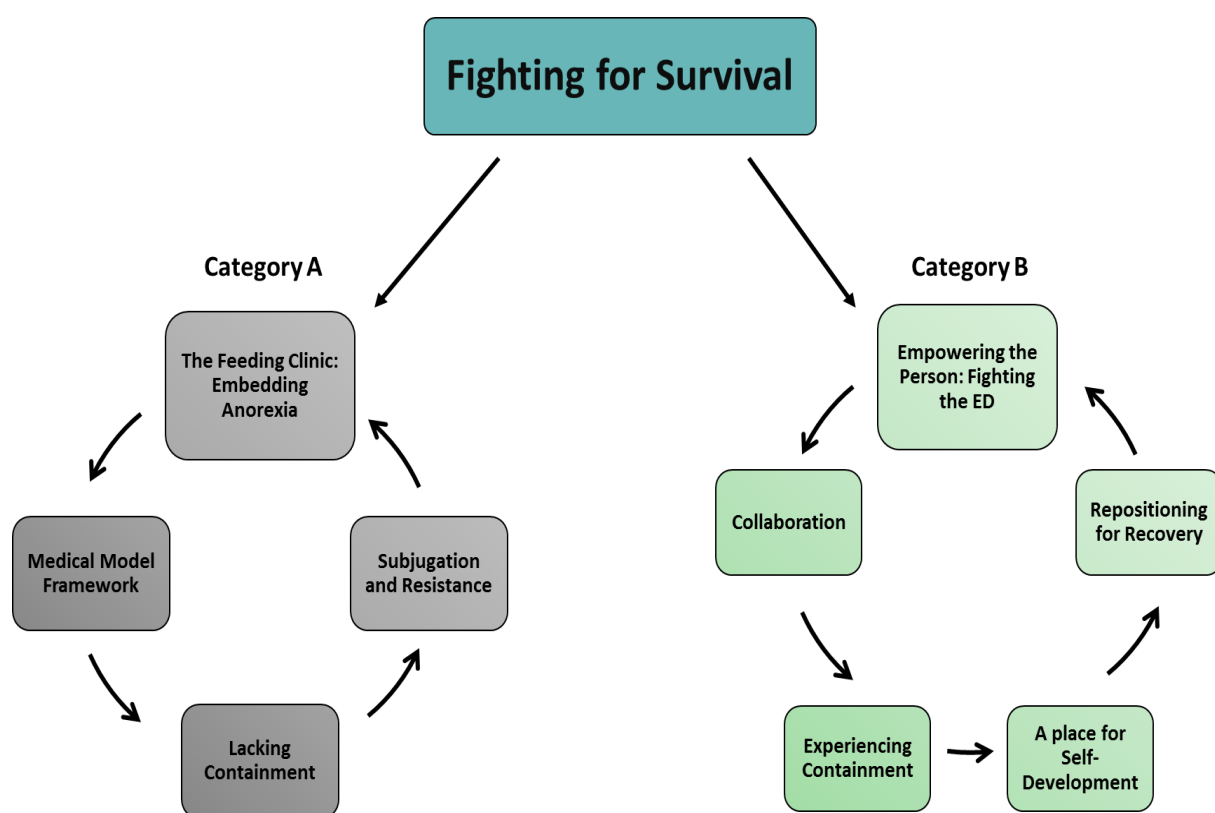


Fig: 1. Model of the Theory ‘Fighting For Survival’.

Overview of the Findings

The first category, titled “*The Feeding Clinic: Embedding Anorexia*”, examines the social processes that ultimately lead patients to ‘fight for their survival’ through establishing a position of resistance directed against the treatment process itself. It identifies the how the contextual conditions arising within services principally informed by a medical model framework cultivated a social order defined by relational animosity between patients and staff. This interpersonal context was found to inform patients retreat into positions of distrust, withdrawal and resistance towards the treatment process and was ultimately understood to lead patients towards a deepened state of dependence upon ED-related behaviours alongside an embedding of their ‘anorexic’ identity.

The second category, titled ‘*Empowering the person; Fighting the ED*’, articulates the processes whereby inpatient treatment was understood to support patients’ development of resources to engage in their own recovery. It identifies how the contextual conditions of a person-orientated ethos cultivated connection and trust within staff/patient relationships and supported patient engagement in treatment by empowering the patient to reclaim their personal autonomy within the recovery process.

The separation of these processes reflects participants’ tendency to compare constructive or destructive inpatient experiences within interview accounts, creating a natural split between these two faces of patient experience. Furthermore, patients positive or negative responses to treatment corresponded, almost entirely, to distinct types of treatment context embodying different philosophies and approach. Negative responses to treatment were found to be associated with services underpinned by a medical model, which were understood to focus treatment on patients’ weight-gain and be aimed at physical recovery. Positive responses to treatment corresponded to services underpinned by a person-orientated

philosophy, focusing treatment on psychological development, aiming towards emotional and cognitive recovery alongside physical restoration.

This paper shall first describe Category A: *‘The Feeding Clinic: Embedding Anorexia’*, detailing the various themes by which this category is identified. This will be followed by analysis of results comprising Category B: *‘Empowering the Person – Fighting the ED’*.

Category A “The Feeding Clinic”: Embedding Anorexia’

This category identifies the process by which patients’¹² relationship with their eating disorder was found to be reinforced through undergoing inpatient treatment. Participants’ used the term ‘Feeding Clinic(s)’ with colloquial familiarity to denote treatments they viewed as being “all about the weight”¹³. This view of treatment emerged from patient observations across a range of structural procedures and social interactions, which culminated in the patients’ belief that the *only* real interest of treatment concerned ‘weight restoration’. This category is comprised of 3 inter-related themes: ***a) Medical Model Framework; b) Lacking Containment; c) Subjugation and Resistance***. These themes are organised and discussed in terms of the specific social phenomena they each illuminate.

Theme a) Medical Model Framework

This theme reflects the types of negotiation emerging within ‘Feeding Clinic’ contexts understood to be principally driven and organised according to a medical model framework. Three distinct types of negotiation were found to comprise this theme: ***a) 1. Standardisation; a) 2. Pathologisation; a) 3. Fast-Tracking Weight-gain***.

¹² All the participants in this study spoke of their experiences as a patient. I therefore refer to participants as patients interchangeably throughout this study.

¹³ Text bracketed by double quotation marks denotes phrases used by participants verbatim

These three processes examine how, and to what effect, treatments characterised by a weight-gain agenda implement a standardised treatment approach, pathologise the patient and generate a non-collaborative environment between patients and staff. Figure 2. presents an overview of theme a) *Medical Model Framework*.

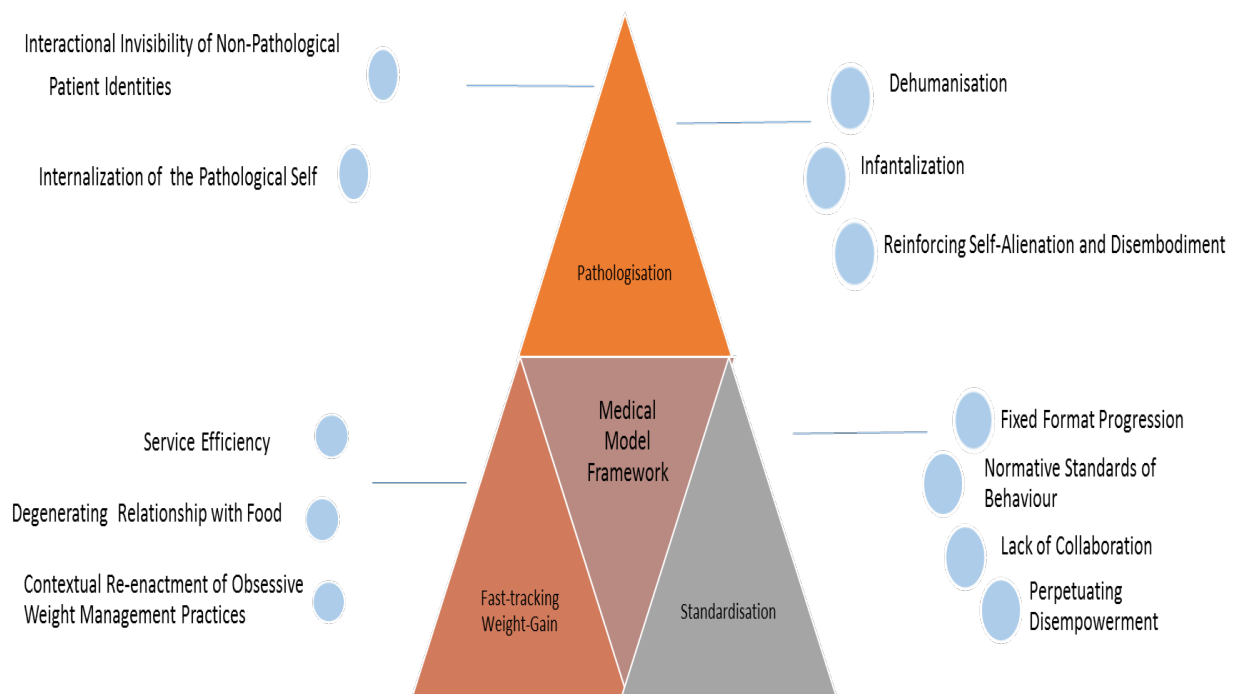


Fig: 2. Category A, Theme a) *Medical Model Framework*

a) 1. Standardisation

The critical tone adopted by participants in speaking of “Feeding Clinics” was consistently targeted towards their view that these services maintained a standardised approach toward the treatment process. In being described as contexts that adopt a ‘one size fits all policy’ “100% standard”, “generic” treatment plan to all patients, ‘Feeding Clinic’s’ were referred to as ‘regimes’ in which patients sense of individuality was disconfirmed and their individual needs beyond staff’s remit of care-provision:

“Sometimes it did just feel like it was a protocol, and what I needed specifically wasn’t taken into account.” (Helen)

*“It’s too hard work to treat you as individuals, ...[we] can’t individualise your plan or get to know you as an person because it’s too much effort ... so we will just treat you as if you are all the same, you are all the same illness.”
(Iris)*

Paraphrasing staff’s verbal statements, Iris presents a rationale for treatment standardisation based on simplifying managerial demands, arising from her understanding that staff perceived patients as requiring ‘too much effort’ to engage with individually. Furthermore, she asserts that treatment standardisation generates an homogenised conception of AN in which patients ‘are all the same’. A standardised and linear format of progression by which patients could progress through treatment appeared to undermine the therapeutic value or relevance of treatment procedures, since a patient’s specific difficulties and individual support needs were categorically overlooked. In cases such as Becky’s, where bulimia rather than restriction was the primary issue, activities became “meaningless” since they failed to target the problematic behaviours:

To them it’s progression if you’re doing cooking group. I explained that those aren’t my problems, but I didn’t fit the protocol and therefore it was meaningless (Becky)

No matter how much bingeing and purging you are engaging with...the problem became my weight and not the behaviours (Becky)

Treatment standardisation was also understood to generate a simplified and narrow conception of recovery determined solely by the successful achievement of patient's weight restoration:

It was just like, how to cure an eating disorder, make them eat 3 meals a day and weigh them...And if you put on weight you're fine, and if you lose weight you're not fine. (Emily)

Emily suggests here that in clinics aligned with the traditional medical model that seek a 'cure', the concept of 'treatment' amounts to the successful enforcement of food consumption. Feeding clinic's framing meals as "a form of group therapy" (see Treasure, Schmidt, Furth, 2003:354) appeared to provide a discursive means of justifying meal-provision as a replacement for psychotherapeutic services, the lack of which participants fiercely criticized.

Standardisation also emerged through the establishment of normative standards of behaviour:

They kept saying this is normal, that's normal. But to me that's not normal. So literally they were replacing my ED rules with a new set of rules, which I didn't find helpful. (Helen)

Also identified in Boughtwood and Halse's (2008) research, Helen here voices how services cultivated ridged and problematic categorisations regarding 'normal' behaviour. Helen's experience of these standards as arbitrary and excessive leads her to view them as an oppressive method that operate to command patient conformity that mirror the pernicious controlling character of her ED.

The lack of opportunity for patients to collaborate in treatment planning signified possibly the most problematic issue resulting from treatment standardisation. Participants frequently expressed how undermined and silenced they felt by having no control or influence over their treatment. Lacking representation in meetings, or a means of negotiating with treatment objectives, participants reported feelings of disempowerment and apathy:

I didn't feel like I had a say in anything...so I didn't bother trying [to communicate] (Fiona)

It was very distressing...I felt really really helpless...[the] frustration [of] not being listened to...I feel they had this very linear, standard, prescriptive view... it works on their terms and that's what you do...being a patient makes you feel powerless (Becky)

This finding parallels other studies that identify patient dissatisfaction with treatment regarding the lack of opportunity to be involved in treatment-plan decisions (Malson, 2004; Valenti et al., 2014) and the powerlessness that emerges in feeling their personal autonomy undermined (Evors et al., 2003). The counter-productivity of excluding patients from the treatment planning process is further understood when considering participants narratives

regarding the development of their ED, which was almost consistently framed as a response to an underlying experience of disempowerment in their lives and whereby food control had become the only means by which they could achieve a sense of agency. Cathy for instance states:

As soon as I feel out of control or panicked in life then the eating disorder thrives on that. (Cathy)

Recreating a social environment in which patients feel powerless therefore signifies an aspect in which the treatment context replicates the conditions under which patients' illness thrive (also see Boughtwood & Halse, 2008; Malson, 1998; Gremilion, 1998, 2002; Hepworth, 1999; Eviors et al., 2003). Moreover, the enduring and inescapable experience of powerlessness fostered feelings of futility and self-loathing:

When I was in the hell holes, where everything was done, I didn't have any controls, I could just get on with hating myself through the whole thing. (Fiona)

Disempowerment was also understood to affect and undermine staff members, who were viewed as lacking autonomy to make decisions:

They go along with the system, the system being this prescriptive, formulaic set of responses... that's what the senior staff do and that's what they're expected to do...within that system. In some ways their hands are tied,

there's not much they can do as an individual, they can't really go against the system. (Becky)

Everyone was so scared of deviating from whatever the protocol was. (Becky)

Becky's portrayal of treatment as a social hierarchy that demands administrative conformity presents disempowerment as an underlying feature of the treatment system. The authority of more senior clinicians was understood to "tie the hands" of front line staff leaving them unable to assume a role of responsibility in making decisions. Becky's account further suggests such structures generate an automated mode of operation in which staff regurgitate a "formulaic set of responses" in facing patients' questions. Staff subsequently came to signify for patients merely a mechanism within the regime:

The staff just imposed their regime, that was their job, that's what they had to do. (Fiona)

A definitive hierarchical structure of power and staff status thus appeared to negatively determine relational interactions on the ward, whereby staff continually deferred responsibility to another staff member. Similar to Tierney's (2008) finding where patients viewed staff as "just going through the motions", Becky reported feeling perpetually "fobbed off" or "lied to", resulting in her "going round and round in circles" whilst "nobody could give you an answer". Patients sense of disempowerment thus appeared to be informed by perceiving staffs' lack of agency or responsibility as a normative and collective feature of the treatment culture. Corroborating this finding, Long et al (2012), Ramjan (2003) and Malson

& Ryan's (2008) qualitative studies report nurses criticising their lack of opportunity to influence treatment decisions, feeling "marginalised within 'the multidisciplinary team'" despite their crucial role in carrying through the team's decision. This cultural feature also appeared to deepen patients sense of depersonalisation within these contexts, further marginalising the role of relationship within the recovery process. Perceiving staff as complicit managers of a behavioural regime led patients to conceive the treatment context as one that nullified relational utility altogether:

They were just the people that managed what I had to do...I didn't feel there was any thing I could do about my situation so I didn't bother trying. (Fiona)

I just felt there was no point, they clearly didn't understand um...So I just didn't bother to talk to them. (Becky)

Fiona and Becky's relational apathy and disinterest appeared to emerge from the underlying experience of lacking a sense of agency in the role of patient. In the absence of being able to have an impact on the other, the utility of interaction disappears.

a) 2. Pathologisation

Participants repeatedly expressed how their diagnosis occluded other dimensions of their person and identity within the treatment context. To my enquiry about the nature of patient/staff relationships participants replied:

[Staff were] very very patronising. Did not see you as a person... 'oh that's just the eating disorder talking', was the standard response... basically all of these thoughts and feelings are a consequence of having a low BMI. (Becky)

Things [were] seen in a certain light because of your illness. (Helen)

Patient criticisms of being treated as an illness rather than a person has been reported in several other studies (Tierney, 2008; Malson 2004; Eviors et al., 2003; de la Rie et al., 2006). Viewed through the interpretative lens of the AN diagnosis, participants described how all aspects of their behaviour, motivation and affect were perceived by staff as a manifestation of the illness, in which “everything you say is part of the disease' and 'everything you do [is] analysed as anorexic” (Malson et al., 2004:481). Participants narratives thus reflect Malson’s assertion that when 'the eating disordered patient' is constructed only in terms of her pathology" “no place or space [is left within] which 'she' can articulate a valid view" (p.482). Boughtwood and Halse (2008) also corroborate this analysis, reporting how staff’s imposition of a biomedical discourse invalidated patients’ perspective by constructing them as “cognitively impaired and not able to 'see properly' because they are malnourished" (p.276). Staffs’ pathological perspective was seen to have a highly deleterious effect upon the patients’ subjective sense of self, affecting not only their core sense of self-worth, but also shaping patients view of themselves in pathological terms:

It was brutal. You didn't feel like a person, you just felt they were treating an illness, but that illness wasn't attached to a person...I couldn't distinguish between me and my eating disorder. No I was like. This is just who I am. This is literally just who I am... this is how it's always going to be. (Fiona)

Fiona here articulates how a pervasive medical-model discourse fosters an essentialised conception of herself as inevitably eating-disordered. The ‘brutality’ Fiona refers to applies to the construction of the illness as detached from her existence as a person. If we consider Rich’s (2006) proposition that the anorexic’s sense of alienation from her body is perpetuated by the way others ‘read’ the anorexic body in terms of pathology, treatment’s pathological view and objectifying practices is understood to reinforce and enact the anorectic’s experience of self-alienation and disembodiment that underpins and enables their capacity for self-starvation.

In contrast to the psychiatric view that AN pathology “reduces all people with it to a lowest common denominator...[and] inherently...[involves] the loss of individuality” (Crisp 1984:226), participants in this study present their loss of individuality as an effect of the treatment’s procedures, which were felt to actively devalue patients’ non-anorexic identities. Patients’ progressive loss of contact with aspects of their identity unrelated to the illness constituted such a powerful form of denigration that it was often felt to foster a perception of being actively dehumanised by staff members:

There was no understanding... they just scowled at you...it’s as though you weren’t human, you weren’t in their eyes, you were just an illness. (Iris)

They don’t even treat you like a human being, let alone somebody who is capable of intelligent or rational thought. (Becky)

Becky here indicates that worse than being de-validated in social status as a patient, is the experience of being denied recognition as a human being. Walker (2008) proposes that the

implicit allocation of the patient as “less than human [and] unworthy of respect” (cited in West, 2005:107-106) arises as a consequence of the “power-over paradigm” existing between patients and staff. Staff’s power over patients and their presiding focus on the ‘physical’ dimensions of patients’ health and illness appeared to generate staff/patient relationships characterised by emotional neglect:

Nobody said, are you ok. It was just all very clinical, it was all just about numbers. (Karen)

Doesn’t matter about how you are feeling, you’re not eating. That is the message that I interpreted. (Anna).

The experience of being infantilised was also a common feature of pathologisation:

I felt they treated you like a child, or like an incompetent person, the way they spoke to you. They didn’t take you seriously. (Becky)

As Malson (2004) explains, “the particular way in which ‘she’ is constructed” in her pathological state of “insanity”, “like a child” or “an incompetent person” precludes “the possibility of being taken seriously” (p.482). Patients opinions are therefore treated as trivial, which, Malson and Ryan (2008) emphasise, signifies a distinctly female status and exemplifies how treatment reconstitutes the cultural construction of femininity as deviant and deficit. The internalisation of this subject-position was expressed by Cathy who, undergoing repeated admissions, progressively came to “[feel] more and more and more of a child” and learnt to believe she would be forever dependent on others to feed her. As if ‘being ill’

established patients' status as 'dependents', participants described, with a certain horror, witnessing others regress into infantile states:

These patients are forced back into a child-like state and they're cuddling these teddy bears because that's all the love they're going to get in here.
(Iris)

The process of infantilisation is here framed as a response to a context that fails to offer emotional nourishment, invoking images of profound dejection and desperate attempts to self-soothe.

Participants insistence that eating-disorders are "not just about the weight" and emphatic assertions that the 're-feeding' method "never works" communicated how deeply misunderstood they felt as people diagnosed with an eating disorder. Participants claimed instead that eating disorders, at heart, are an emotional and cognitive issue that results in problematic behaviours:

You can sort out my weight but, that doesn't really fix the problem...[The behaviours] are a symptom of the problem - negative thoughts and extreme dislike of myself, feeling completely unacceptable. (Becky)

There wasn't an understanding of it. It was just like, how to cure an eating disorder, make them eat 3 meals a day and weigh them... And that's just not the case, for anyone with an eating disorder... I can still put on weight and still have a raging eating disorder' (Emily)

If you focus completely on weight it's a losing battle. It really is. It's completely the wrong way round. (Cathy)

Despite acknowledging that “of course, weight has to be a consideration”, participants unanimously expressed a need for inpatient treatments to address and respond to their emotional distress and cognitive disturbances, since “weight wasn't going to make the eating disorder go away” if underlying issues driving the behaviours remained invisible and unaddressed. As Eivors (2003) articulates, this focus “enable[s] the individual to continue their effective strategy of focusing life around food as a means of coping with stress and other issues, possibly inadvertently reinforcing the eating disorder” (p.98). Indeed, Cathy’s statement seems to verify this:

They really are...idiots, when it comes to treating people with anorexia in the NHS. I think they've made my illness so much worse in many ways. (Cathy)

a) 3. Fast-Tracking Weight-gain: “Weight-gain - that’s all they care about”

The objective to meet the ‘target weight’ prior to discharge was seen by participants as the overarching framework around which treatment procedures and interactions were organised. Determined by precision and efficiency, weight-gain targets were identified at the outset, to be met within a specific time frame, usually determining a weight increase of between 1 and 2 kilograms a week. Subsequently, food became a signifier of measurable calorific value:

They... do everything by calories., like they'd say, this week you are on 2200 calories, it was very precise. (Fiona)

The explicit construction of food in terms of calorific value is destined to impart the practice of calorie counting into patients' behavioural repertoire, or to reinforce this practice if there previously (also see Gremillion, 2002). Services enforcing a high rate of weight-gain within short periods of time led also led patients to feel psychologically overwhelmed:

I put 4 stone on in 4 months and it was just too much. I couldn't cope with it.... you are like, oh my god, how do I deal with this, I have no idea how to deal with this. (Gina)

Rapid weight-gain appeared to exacerbate patients experience of feeling out of control (also see Boughtwood & Halse 2008; Eviors et al., 2003), contributing to experiences of terror and self-disgust. In the absence of a collaborative working alliance, patients underwent dramatic bodily changes that felt forced upon them. Cathy explained:

I just couldn't handle that. It felt like it happened too quickly for me. I just needed a slightly slower approach and then I would have been on board with the whole treatment thing a lot more. I would have trusted my body; I would have trusted the team a lot more. (Cathy)

The speed with which treatment is here reported here to achieve specific weight-targets leads not only to psychological overwhelm, but a regression of trust both in the treatment process and her own embodied experience, which led to a withdrawal of willingness to engage in the recovery process.

Treatments approach of ‘fast-tracking’ weight-gain was also understood to reflect a more practical pressure, responding to the high demand for patient admissions without sufficient resources to provide care:

They were running out beds so they needed to get rid of patients as quickly as possible. (Becky)

They want you in and out as quick as possible (Cathy)

In view of this perspective, participants depicted the function of ‘feeding clinic’s’ as merely an “emergency pit-stop” in which, like a conveyor-belt system, patients were processed as efficiently as possible in to and out of the system, creating a context that could only manage to provide patients medical stabilisation at the exclusion of many other needs. This appears to reflect a trend in our current cultural ideology in which efficiency of time and money signifies the superordinate property¹⁴ by which health care services are devised and administered (Ritzer, 1983).

Ironically, possibly owing to a shortage of beds, services were reported to deny admission until patients’ weights had fallen to dangerously low levels, at which point turning towards recovery was felt to be so much more difficult:

In the NHS you have to be under BMI 13 or 14 before you even get on the ward, and you’re so ill and deluded by then that it’s so much harder [to get better] ...I think it’s so important to be able to ...help them before their weight drops to such critical levels. (Cathy)

¹⁴ This property may be associated to Key Performance Indicators, which most organisations maintain as a means to evaluate their outcomes.

Food-focused treatments also seemed to exacerbate a defining characteristic of the illness – the fear of food. Alongside the dread of having to consume large quantities, participants provided grotesque descriptions of food practices within treatment:

The food looked like a dog's dinner that's been dropped on the floor, that somebody's been sick on and they've scraped it back onto your plate.
(Cathy)

In the NHS, I would be given 19 biscuits a day, 90% of them stale... well that's just disgusting...Over seven months I had one piece of fresh fruit ...it was appalling. (Cathy)

They seem to take [food] things to extremes in these institutions. (Iris)

There were stages when I thought the concept of food was vile...I've only got more and more and more afraid of the food... but that's probably more of the treatment that did that. (Cathy)

[Inpatient treatment] really did make my relationship with food significantly worse. (Iris)

Whilst it is to be expected that an eating disorder treatment context would struggle to replicate the social meanings food normally carries in everyday life, the provision of unappetising and repetitious foods was found to create a social reality in which the notion of

food was constructed solely in terms of its medical function and aggressively (re)inscribed patient's aversion to food and eating (also see Hepworth, 1999; Gremillion, (2002; Boughtwood & Halse, 2008; Reid, Burr, Williams, Hammersley, 2008).

Theme b) Lacking Containment

The theme Lacking Containment identifies participants experience of Feeding Clinic contexts as unsafe and failing to provide patients protection from the tyranny of their ED. This theme is described through two types of negotiation: ***b) 1. Context as Chaos*** and ***b) 2. Boundary Ambiguity***, as represented in figure 3.

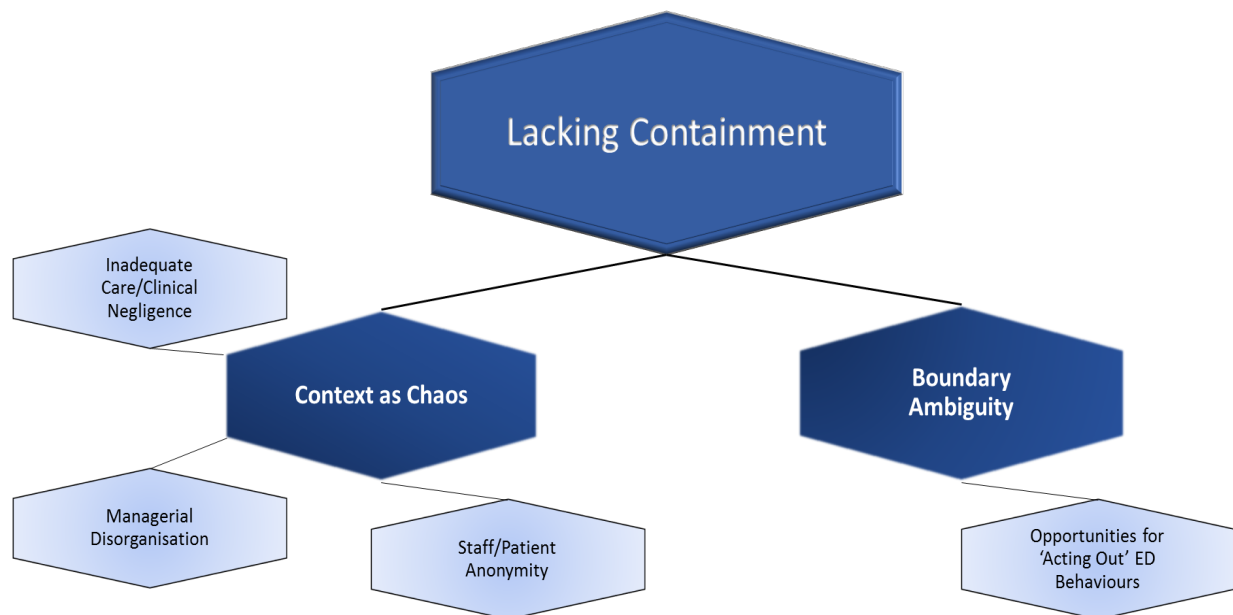


Fig. 3. Category A, Theme b) Lacking Containment

b) 1. Context as Chaos

Additional to staff's failure to provide patients a sense of emotional containment, the managerial challenges of providing a well-resourced environment exacerbated patients experience of being unsafe and uncontained:

It felt like complete chaos...things just didn't happen...ran out of basic everyday foods quite regularly...continuously not enough staff...completely disorganised. Yeah, which made me think...how the hell is this gonna help.
(Becky)

There were alarms going off, because people needed restraining. There was never really any staff around. (Fiona)

People were left in states of distress with nobody responding to them. Horrible. Really horrible. (Emily)

Participants observation of managerial disorganisation and staff shortages was seen to severely undermine their sense of trust in treatments allegedly intending to provide patients safety and support. Services' heavy dependence on bank staff was persistently criticised by participants. In addition to the anonymity that emerged between patients and staff whereby "you didn't know them, they didn't know you.", the use of bank staff was associated to the cultivation of managerial chaos and inadequacy of care:

They didn't know how to treat me. They didn't understand eating disorders.
(Fiona)

Clueless doesn't sum it up. (Helen)

Nobody knew what they were doing. (Gina).

Participants perception that bank staff were ill-equipped to provide care and failed to understand eating disorders was widespread in these contexts. Jarman's (1997) study identifies that caring for ED patients is particularly demanding for non-specialist clinicians with little training or experience in the area, indicating that the employment of bank staff may not be an appropriate means of resourcing ED inpatient services. The dangers resulting from this issue is captured in Fiona's account, in which she reports a patient's suicide attempt while under supervision in an inpatient service:

*I discovered that a girl had taken an overdose and collapsed on the floor,
while the staff were taking a cup of tea in the staff room. (Fiona)*

By presenting staff as a group occupied by tea-making, Fiona portrays clinical negligence as emerging from within the treatment culture which, through its very routine operations, leaves patients open to act out potentially fatal instances of self-harm.

b) 2. Boundary Ambiguity

Staff's failure to provide consistent boundaries was also highlighted as a core issue within services relying on temporary¹⁵ staff:

¹⁵ Otherwise referred to a 'bank staff' or 'agency staff'.

They'd let you get away with stuff that you shouldn't. So...there was a massive safety issue there. I used to worry...get really really anxious...that it was gonna be all agency staff and I wouldn't be able to cope. (Helen)

When you have a weak member of staff, your illness just plays into that. (Cathy)

That makes our journey harder, coz that feeds [the illness]. The illness will grab that opportunity. (Julia)

In one respect, these accounts articulate the difficulties patients face when supervised by staff who lack the skills to maintain treatment boundaries, or fail to provide the patients with adequate support (see also Long et al., 2012). Patients construction of their difficulties points to an additional issue. Contrary to studies examining clinician perspectives, which find descriptions of difficult patients as "manipulative" (Long et al., 2012:241), 'aggressive', or 'cunning' (Malson & Ryan 2008:120), participants here communicate their desire for a safe and contained environment that can protect them from 'acting out' the compulsions associated with their ED. In this study, participants described the difficulty in resisting the compulsions of their ED when held within a context that enables it to express itself. Participants articulate this conflict through constructing their illness as a separate entity that impinges its will on them. Without the containment of a clear structure held in place by experienced staff members' patients felt more vulnerable to their illness, which led them to find holes in the system and to use staff ignorance as leverage to align with their ED.

Theme c) Subjugation and Resistance

The theme ‘Subjugation and Resistance’ identifies the reciprocal processes by which staff enforced the treatment ‘regime’ and patients responded to it. The term ‘subjugation’ conceptualises the processes by which the ‘regime’ maintained control and orchestrated patients’ submission to treatment demands. The concept of ‘resistance’ identifies the subversive means by which patients defended against this subjugation and undermined treatment procedures. Whilst these processes are distinct, patients’ manifestations of resistance tended to be maintained or expressed through acts upon their own body, which led to a reinforcement of their ED behaviours, indicating that patients’ means of resisting treatment ultimately resulted in their continued subjugation to the ED. This theme identified two types of negotiation: *c) 1. Strategies of Subjugation* and *c) 2. Strategies of Resistance*.

Strategies of Subjugation are identified in the structural and interpersonal tactics effecting a system of “Reward and Punishment”. *Structural Tactics* include 1.(ii) *Ultimatums*; 1.(iii) *Time*; 1.(iv) *Space*. *Interpersonal tactics* include: 2.(v) *Staff Animosity*; 2.(vi) *Treatment as trauma: “Tearing lovely people apart”*.

Strategies of Resistance are identified in the subtitles: 2. (i) *Resistance through Withdrawal*; 2. (ii) *Resistance through Compliance*; 2. (iii) *Resistance through Subversion*; 3. (iv) *Undoing treatment*, as presented in figure 4.

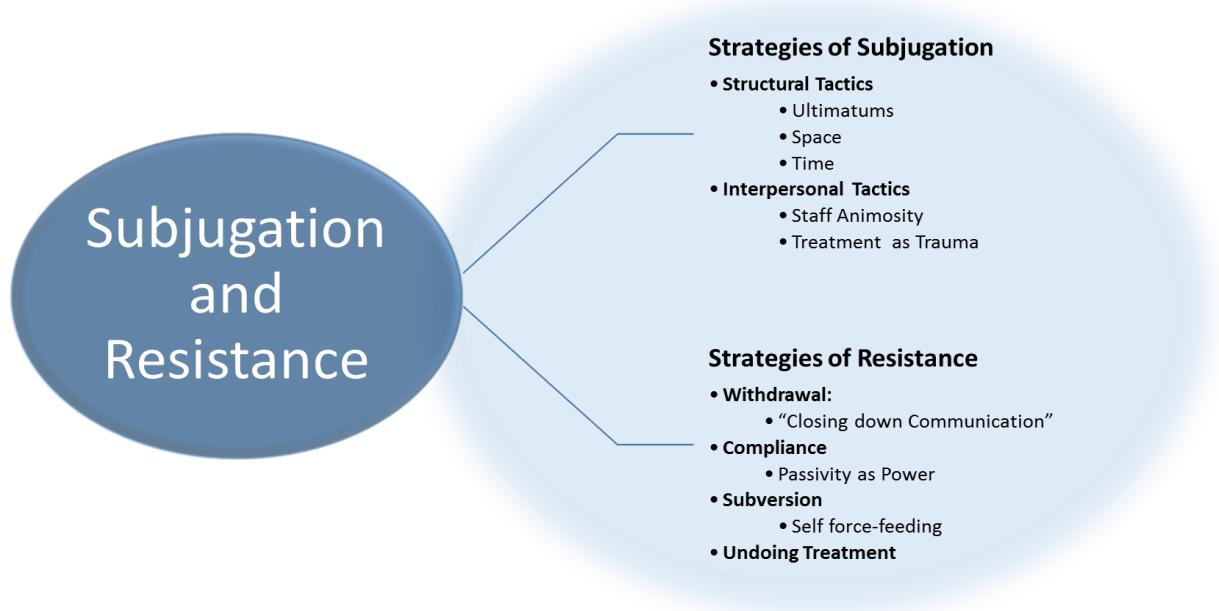


Fig. 4. Category A, Theme c) Subjugation and Resistance

c) 1. Strategies of Subjugation

Structural Tactics

Participants described ‘Feeding Clinics’ as places that govern its patients through systems of ‘reward and punishment’ wherein ‘liberties were taken away’ or granted according to patients’ deviant or compliant behaviours and weights. As multiple authors have previously noted: “[ED] nursing often involves modifying patients' behaviours through surveillance and discipline” (Ryan et al 2006:129; also see Garrett, 1991; Gremillion, 2003; Ramjan, 2004) by using operant behavioural techniques such as making patients “earn privileges by putting on predetermined amounts of weight” (Jarman et. al., 1997:144). According to Jarman et al. (1997), this strategy “enables the health-care professionals to maximise their control over the patient's eating behaviour” (p.144). In this study, the view of treatment as a system of ‘reward and punishment’ was understood to reflect a structural property of services that extended their arena of control beyond eating behaviour to include various forms of bodily management.

1.(i) *Ultimatums*: Upon instances of patient food-refusal, participants commonly reported facing an ‘ultimatum’ between accepting a nasal gastric tube or being sectioned. These confrontations appeared to demonstrate the aggression staff were willing to use in asserting their control so that patients saw no alternative but to “toe the party-line”. Explaining how sectioning was “always” used as a “horrible threat”, Fiona describes staff response to her refusal to eat a Mars-bar:

“They were like – “Fine! We’ll melt it down for you, add some double cream to it and turn it into a drink, and if you don’t drink it we’re gonna put it down a nasal gastric tube”. It was horrific.” (Fiona)

Nasal gastric feeding refers to a force-feeding procedure that is clinically and legally justified to ensure patients don’t die from the effects of starvation (Silber et al., 2003). This account however presents the use of this procedure without medical necessity as a means to coerce patients to comply with routine treatment demands by threatening to increase their food consumption beyond the formal requirement.

1.(ii) *Time*: Feeding clinic’s construction of time also appeared to be experienced as a vehicle of punishment. Iris’s use of discourse for instance, presented treatment as form of incarceration, referring to patients as “inmates” and treatment admissions as “a sentence” requiring patients to “do their time”. Participants conveyed the crushing sense of boredom arising from a lack of meaningful occupation they felt whilst in treatment. Faced with hours of unstructured time patients reported “twiddling thumbs” all day, enabling them to fester in self-loathing:

When I was in the hell holes, where everything was done... I could just get on with hating myself through the whole thing. (Fiona)

Participants description of time constraints during meals also communicated the fear and panic arising from the pressure to consume meals within a limited time-frame:

I would literally be shaking from anxiety...I couldn't even keep the peas on my fork coz I was just thinking oh my god, the time is ticking away. (Cathy)

It is well documented that inpatient services tend to impose time restrictions on the basis that anorexic patients take “exceedingly long periods to eat” (Boughtwood & Halse, 2008:270; also see Eisler, Dare, Russell, Szmulker, le Grange, Dodge, 1997; Garner & Garfinkel, 1997). Subsequently, “it has become commonplace for strict boundaries...[to be] maintained around finishing meals on time and eating everything provided” (Treasure et al., 2003:354; also see Long et al, 2012). Recent research however has also shown that “greater psychological distress in individuals with eating disorders is actually associated with less behaviour change” (Geller et al., 2001:371), indicating that mealtime conditions exacerbating what is already a stressful event for patients (Long et al, 2012) are counterproductive for their recovery.

Controlling patients' level of contact with family and friends according to weight-status was also viewed as a feature of reward and punishment systems. Fiona explained:

If you didn't put on a kilo a week...[even though you're] 95% weight restored - not allowed out to see your parents. (Fiona)

Reporting a strict limitation to phone access, Helen states:

At X we got so isolated...lost contact with all my friends. (Helen)

The experience of isolation, commonly identified as a perpetuating factor of ED behaviours, presents the treatment context itself as cultivating the conditions by which patients ED is reinforced.

1.(ii) Space: Describing the physical space as being ‘like a prison’, participants reported a variety of restrictions over their bodily movement:

You weren’t allowed to put your feet up, you had to sit there, feet forward, looking forward. (Iris)

If you giggled your leg, they’d give you a biscuit. (Fiona)

Not even allowed out in the garden. (Fiona)

By constituting patient’s bodily movements as a manifestation of the AN pathology, presumed to be motivated by patients’ compulsion to ‘burn calories’, the detailed scrutiny of patients’ every action is legitimised and incorporated into service’s arena of governance alongside psychiatry’s authorisation to modify patient’s expressions by threat of punishment. This finding is mirrored in Ryan’s (2006) study, which documents nurses sense of obligation to “‘watch that they don’t exercise’ by ‘modifying patients’ behaviours through surveillance

and discipline” (p.129). Disturbingly, participant’s descriptions of their ED as a punishing system of control via self-subjugation and self-restriction towards actions extending beyond food-related phenomena appears to mirror treatment’s approach to the bodily regulation of patients.

Interpersonal Tactics

1.(iv) *Staff Animosity*: Participants appeared to feel subjugated by the animosity they felt from staff:

They are just so unfeeling and pissed off all the time. (Iris)

You get the impression that they hate their job. (?Cathy)

Nobody gave a shit what you had to say. (Becky)

This appeared to shift seamlessly into the experience, or anticipation, of feeling hated:

Some of the staff would even mock me for my eating disorder. (Iris).

They’re gonna hate me now. I’m bad. (Gina)

She [the psychiatrist] hates all her patients...She is a danger to patients... I think she shouldn’t be practicing. (Becky)

Participants also reported feeling persecuted by staff:

The things that people were accused of, that they didn't even do! (Iris)

Staff's expression of negative feelings is presented here as a form of psychological bullying, which Tierney (2008) also found to be "particularly disturbing" (p.371). Staff's hatefulness appeared to be experienced as a consequence of the way in which patients were being constructed pejoratively through their AN diagnosis (also see Tierney, 2008; Dorian & Garfinkel, 2001):

It's just your manipulative brain telling you that, you just want to make things harder... why do you have to make a fuss? (Fiona)

She said to everybody "this is a classic example of an anorexic monster trying to manipulate." (Iris)

Staff are presented here as merging their negative meanings associated to the 'anorexic' pathology with their perspective towards patients' personal characteristics. This appears to facilitate staff's construction of 'anorexia' as being governed by the patient's own volition, whereby the patient is viewed as '*trying* to manipulate' or '*wanting* to make things harder'. Rich's (2006) study parallels this finding, reporting clinicians' view of "perceived 'voluntarism'" (p.290) in the patients eating disordered behaviour. Being accused of 'making a fuss' further suggests the behaviour is construed as a method of "attention seeking" (Rich 2006:293). These constructions bear close similarity to the early literature about the condition in which AN is characterised as a self-induced problem of spoiled, deviant women (see Dowse, 1881; Marshall, 1895; Playfair, 1888) stemming from a lack of willpower rather

than understood as “the serious multi-determined illnesses they are” (Dorian & Garfinkel, 2001:12). As Iris’s account exemplifies this construction is compounded when such ‘deviance’ is inscribed as part of the pathological condition, enabling instances of it to be “actively sought out and proliferated as evidence, as the correct interpretation by which to understand patient behaviours” (Rich, 2006:293).

AN patients have a reputation of being difficult to treat and challenging to nurse (Garrett, 1991; Grothaus, 1998; Kenny, 1991; King & Turner, 2000; Vitousek, et al., 1998) and are known to evoke “feelings of anger, hostility, stress, and a sense of hopelessness in...caregivers” (Dorian & Garfinkel, 2001:13; see also Kaplan & Garfinkel, 1999). Participants accounts in this study appeared to reciprocate these feelings of animosity towards staff, creating a relational dynamic in which patients and staff were locked in a “game” against each other. Whilst these negative feelings have previously been framed as transference phenomena in clinical literature (Long, 2012; Treasure, 2003), presumably in the hope of proffering more therapeutic responses from staff, participants accounts indicate that staff’s awareness of transference processes, if present, is making little impact on practice.

1. (vi) Treatment as trauma: “Tearing lovely people apart”: Throughout interviews, participants repeatedly described many treatment practices as ‘*horrific*’, as if trying to communicate how brutal, even barbaric, these environments were. Iris, for instance, struggled through tears to describe witnessing patients being subjected to enforced nasal-gastric feeding:

...I just remember this scream, “they had pinned her down and [were] dragging her into the treatment room and forcing a tube up her nose, and you

could just hear her screaming. They...just left her in a pile in the hall...they would have killed her...We could hear the girls in the acute screaming as they dragged them down the hall by their wrists and ankles. (Iris)

Through an echo of screams, the violence and brutality conveyed in this narrative depicts Iris's horror at the systematic form of abuse she perceives (see also Valenti et al., 2014). Iris's description of treatment as a place that 'tears lovely people apart' delicately articulates a process of traumatic annihilation. Speaking about different services, participants explained:

I still have nightmares, because it was so awful...her screaming. I can't describe it, it was awful...it was like hearing someone be tortured... I suppose in a way it was. (Helen)

That place messed me up so much. I still have nightmares about that place. (Iris)

The persistence of nightmares, recalling the horror of inpatient experiences, indicates that patients suffered long-term psychological damage from these admissions. Indeed, Gina describes post-traumatic symptoms persisting for 20 years:

When it's getting to half-past one...I start to tremble and quake... psychologically, I say to myself "if you're not finished in an hour you're going to get punished". Coz that's exactly what they were doing in [that clinic]...even now, at 43 I'm scared stiff of what people are gonna do. (Gina)

c) 2. Strategies of Resistance

Within contexts that felt so frightening and unsafe, any prior intentions to engage in a genuine recovery process were overridden by a determination to merely survive the admission and “get out of here”. I shall below discuss the various strategies by which patients were seen to achieve this objective, which involved forms of both, and sometimes simultaneously, their submission and resistance to the treatment process.

2. (i) Resistance as Withdrawal: In the absence of trust and therapeutic alliance, patients seemed to resort to their primary means of survival: withdrawal from relationship and alliance with their illness. This strategy included methods of “closing down communication”, “turning in on oneself” or “keeping it all in”; phrases in which we see a re-direction of attention away from the outside world towards insularity, associated with obsessive thinking and an accentuated focus upon weight and food concerns. Participants association of “coping alone” with their early development and evolution of ED behaviours resonates with a Relational-Cultural Theory perspective that frames ED behaviours as a means of facilitating a dissociation from the world around her (Jordan, 2010; Tantillo, 2006). The act of withdrawing however, whilst serving a protective function, further isolates patients and curtails the possibility to explore their difficulties through relationship:

What’s the point in talking to anyone and saying how I’m thinking and feeling if it doesn’t get listened to, nothing changes. (Becky)

Becky’s act of withdrawal appears to constitute a dead-lock in which she assumes an impenetrable position closed off to influence from the other or any openness to movement within herself.

2. (ii) Resistance through Compliance: Adopting an attitude of compliance was the most commonly adopted method of “getting out”. Here, patients seemed to accept their role as a ‘passive recipient of expert care’ (Joseph, Beer, Clarke, Pickersgil, Swift, Taylor, Tischler, 2009) and allow treatment to ‘do things to them’. Fiona explained:

It was like, I will do whatever it is that pleases you...I know that the only way to get out is to go with the program and to comply because... there's no other way out. (Fiona)

Efforts to “behave well” and “create as little fuss as possible” present ways in which patients pacified and automatised themselves to survive the treatment process (see Appendix 23 for an extended discussion of this). It is also likely that staff’s *habituation* to patient’s emotional self-possession or disconnection fed into staff’s *own* disconnection from, or oversight of, the negative and disturbing aspects of patients’ emotional experience (also see Jarman et al., 1997). As Becky remarked:

I think the staff have no idea quite how unpleasant and distressing and disempowering it is being there. (Becky)

Staff’s implicit abjection of emotion, very likely facilitated by patients own silence and passivity, appears to cultivate a social climate in which staff underestimate the harmful emotional impact of their treatment procedures on patients. The damage and counter-productivity of allowing states of passivity to fester, however, is evident in Fiona’s account

below. In response to my question regarding the cause of her prolonged state of silence, she replied:

As far as I was concerned that was how I was gonna be for the rest of my life. I didn't want to make a fuss...I didn't think that the thoughts I had would ever be able to go away, they were just a part of who I was...I can't do anything to change this. I don't know how to change this. This is how I think. This is how its always going to be...I was just powerless. It was such a circular thing. I mean, I can't remember how many times I've been to [that clinic] now, six or seven? (Fiona)

Fiona's resignation to being powerless conveys an almost determined position of passivity and submission to the illness in which she accepts her pathological constitution and a future life involving repeated re-admissions to inpatient clinics. Despite her experience of powerlessness, Fiona appears to clasp a sense of certainty in this position. Herein she subverts the experience of powerlessness and submission into a powerful stance of resistance to change whereby she claims her ED is impenetrable and treatment ineffectual. Thus, despite the misery and desperation felt within her position, she manifests an autonomy that screams rejection and criticism of the system she is caught in.

Participants appeared to maintain a position of passive compliance through (re)inhabiting a disembodied self, wherein they detached their emotion from their physical, corporeal experience. This appeared to enable patients to submit to treatment demands with behavioural compliance whilst maintaining a stance of emotional rejection toward the process. The act of *appearing* to engage with treatment thus provided patients with means to withhold some intrinsic part of their will, whilst offering their body up to treatment's control.

In this way, patient's passive subjugation implicitly declared these coercive treatment methods to be ineffective and to discredit the validity of its weight-gain agenda.

Patients deepened sense of isolation and anxiety resulting from maintaining this complicit position however generated an ever-widening gap between their actual experience (involving panic and overwhelm) and their pretence of coping with rapid weight-gain. Staffs' apparent failure to pick up on this incongruence and lack of attention to patient's emotional process appeared to reinforce patients underlying beliefs that their feelings, no matter how painful or extreme, "don't matter" and that their 'real self' had no value. The ultimate cost of this false engagement through complicity therefore fell back upon patients themselves in threatening a form of spiritual death:

I just shut off all the human instincts and all feeling just so I could get home...but I was basically dying inside. (Iris)

Alongside their compliance therefore, participants described a growing intensity of despair and anger which was directed in upon their 're-fed' body in feelings of self-revulsion:

I was about 23 (BMI) and I felt disgusting... revolting, and I couldn't cope. (Iris)

2. (iii) Resistance through subversion: Finding the horror of being an inpatient stronger than their fear of gaining weight, some participants described subverting their anorexia through violently force-feeding themselves during treatment. As Iris explained:

That place was such a hell hole, I did everything I could to get out. So I binged massively...I basically stuffed my face to the point I was leaning over the loo every night gagging because I was so full and in so much pain. They didn't stop me. They were fully aware that I was eating loads. They thought it was brilliant, the fact that I was gaining 3 kilos a week.... I look back now and think how on earth did I do that, but I was just so terrified of that place, I just did anything I could to get out. (Iris)

This exert was part of a narrative in which Iris described how she pretended not only to staff, but also to other patients about having a 'recovery epiphany' so that she would be granted discharge. She described how human relationship came to signify a threat to her survival, whilst self-violation offered her access to it. It is hard to believe that staff viewed Iris's behaviour as evidence of genuine recovery. Staff's encouragement of her self-abusive behaviour instead suggests a more ominous and sadistic process, whereby staff were aware of the desperate objective underlying this feeding frenzy, but prioritised their weight-gain goals over the patient's wellbeing, leading them to refrain from interfering.

Other desperate acts of resistance were reported to become routine and definitive of inpatient behaviours. Articulating the panic generated by the threat of nasal-gastric feeding while eating within a limited time-frame, Cathy explained:

You're surrounded by other people who are folding their toast up, sticking it in their pockets, putting the butter all in their hair which I ended up doing as well, but it kind of encourages you to do that because of the panic, and there's someone vomiting down their top next to you, there's someone else putting

something else in the plant... it was just so unbelievably terrifying and traumatising. (Cathy)

While on the surface this form of group behaviour replicates exactly the behaviour that clinicians assume of ‘anorexics’, evidencing attempts to deceive staff by disposing of food covertly (Boughtwood & Halse, 2008) through “cheating” and “manipulation” techniques (Long et al., 2012:241), these behaviours arguably reflect one of the few forms of resistance left available within this “punishing” and “disempowering” context. From this perspective, treatment-resistant behaviour is an outcome of the particular conditions in which patients are situated. Feeling that negotiation was unattainable and honesty impossible within a ‘dictatorial’ environment, patients appeared to see no option but to maintain a guise of engagement through appearing complicit, whilst manifesting acts of deception wherever possible. Nevertheless, the psychiatric conception of anorexic patients as inherently ‘resistant to treatment’ propagates a view of patients’ rebellious behaviour as inherent to the illness. The pervasiveness of this construction was evident in Fiona’s account:

It’s probably the first time when I started to be, like ... rebellious, in the sense that, it was my illness that was being rebellious, because like, I climbed a tree in order to stop my parents taking me back...in the end they had to man handle me in the car...I didn’t hate them, I hated myself for what was happening. (Fiona)

Fiona’s construction of her own behaviour in terms of the ‘anorexic’ pathology not only reflects her adoption of a pathological understanding of her behaviour, but leads her, unavoidably, to locate the blame on herself for being unable to surrender to treatment. In the

absence of an alternative (non-pathological) subject position, Fiona reported withdrawing into a prolonged state of silence following this incident, in which she suffered the strain of internal persecution from her ED alone and degenerated into a state of suicidal collapse:

Near the end of my stay...I couldn't deal with it, I hadn't spoken to my parents or anybody for about 2 months...I was probably suicidal at that point, I just wanted to close up and just not be there, not exist. (Fiona)

Without alternative resources to cope with distress, patient's capacities were overwhelmed, leading them to feel "suicidal just being there". Indeed, several participants stated that in fact they would "rather be dead than go back to [a particular clinic]." This illuminates how the act of stripping patients of their ED without replacing it with other resources presents a life-threatening situation for the patient, since the ED is felt to provide the patient the only way of surviving a hostile or unsafe environment.

3. (iv) Undoing treatment: Having gained weight under coercive conditions rather than negotiated consent, patients' dependence upon their ED as a means to claim some internal sense of agency and control remained intact. Re-emerging from a traumatic environment to face a foreign body not of their own making, overwhelmed by feelings of self-revulsion and self-alienation, patients described reversing the effects of treatment by losing the weight-gained within it:

I was very upset, very angry. And as soon as I got out, my weight plummeted. Within 6 months I had exercised the weight off again. So it was just back and forth, back and forth. (Gina)

As soon as I was discharged, the weight started coming off. I had to get it off. (Iris)

It appears that the detachment required to withstand these treatment admissions resulted in a severe backlash in which treatment was ‘undone’ upon leaving. This led to the “circular thing” of repeated admissions. As Boughtwood and Halse (2008) identifies “hospital regimes will invariably foster a backlash as girls will lose the weight they gained, either within hospital or upon discharge, because hospitalisation has not allowed them to address the issues that underlie their eating problems” (p. 271, citing Segal, 2003; Way, 1993).

The counter-productivity of an authoritarian approach to treatment, which this data indicates as characteristic of medical-model approaches, is that whilst it seems to mobilise patient engagement, internally the patients’ alliance with their ED is strengthened during the treatment process. Without being replaced by something better, participants explained, the eating disorder would do “anything it could to survive”. The person’s experience of being pathologised and treated with hostility lead patients to view the ‘help’ being offered as untrustworthy since staff failed to recognise, value or care for the humanity within the patient. Aside from generating negative beliefs about professionals working in eating disorders, this deepened patients destructive self-beliefs and exacerbated their feelings of vulnerability that enabled the ED to thrive, whilst simultaneously squeezing out the space required to cultivate their sense of agency and responsibility in the process of change. Figure 5 summarises the processes occurring within ‘feeding clinic contexts’:

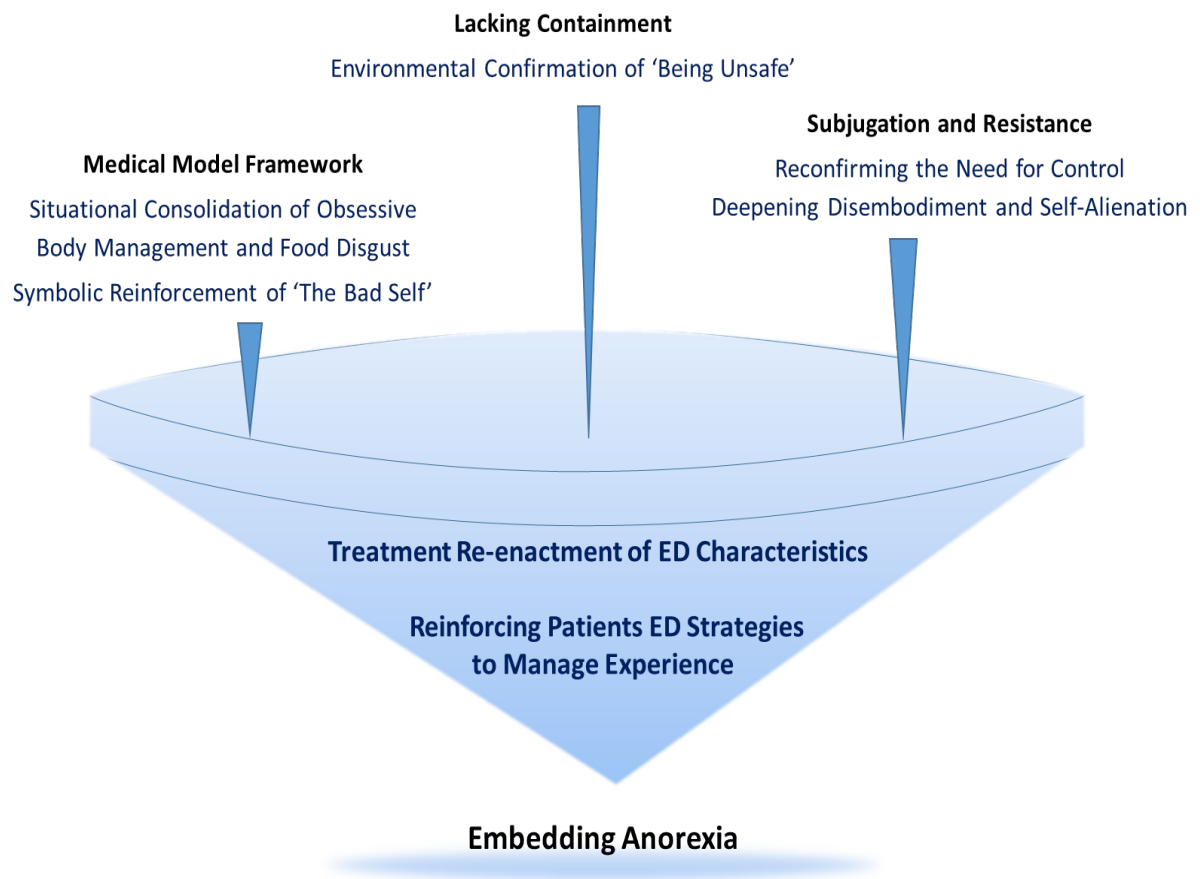


Fig. 5: Model summarising Category A

Category B: Empowering the Real Self: Fighting the Illness

This category identifies the processes by which patients responded positively to the treatment context and were understood to engage in a genuine recovery process during their admission.

The category is comprised of four themes: *a) Collaboration; b) Experiencing Containment; c) A place for Self-development; d) Repositioning for Recovery.*

a) Collaboration

The theme 'Collaboration' describes four types of negotiation: *a) 1. Individualising Treatment; a) 2. Sharing Power; a) 3. Developing Trust - Enabling a therapeutic alliance; a) 4. Devolving Responsibility*, as represented in figure 6.



Fig. 6: Category B, Theme a). Collaboration

a) 1. Individualising Treatment

A core component of collaborative approaches involved offering individualised plans for a patient's treatment. This policy appeared to communicate a service attitude that viewed patients as persons and to cultivate a clinical environment whereby patients felt their fundamental humanity was respected and valued. Infiltrating all levels of staff personnel, this attitudinal quality appeared to exist on a systemic level. Asking participants what they found helpful about good treatment experiences, the reply was almost unanimous:

I think the focus should be more on you as a person. Which I think is the refreshing thing about X. The fact that they do take on what you say, and take on you as a person, take on how you are feeling, as a person, not so much weight. (Cathy)

She had a lot of respect for you as a person, she didn't talk to you as if you were just another patient. (Becky)

What stood out for me was the individuality of care, incredible. (Iris)

It's not like a one size fits all, everything is tailored to your requirements. (Gina)

Cathy here suggests that the experience of being treated “as a person” involves “taking on how you are feeling”, whilst Becky defines it through the experience of being given “respect”. This presents an underlying humanistic ethos that fundamentally de-pathologises the individual and their experiences. As Iris and Gina highlight, being received and listened

to as individuals required a recognition of their specific and unique manifestations of the eating disorder. Subsequently, each patient's requirements and expectations for treatment were identified and responded to. The importance of treating patients on an individual basis has also been identified by Button and Warren (2001) who state that "planners of services for people with anorexia nervosa need to recognise these individual differences and be prepared to tailor services to the consumer's needs" (p.94). These exerts also demonstrate the importance for AN patients to feel that their sense of self, separate from their illness or pathology, is being recognised and validated by the other. This form of recognition appeared to foster a broad concept of recovery beyond weight-gain requirements.

They reiterate all the positives of committing yourself to the programme and what your potential is for life, and it's all positive. (Iris)

Everybody's unique, everybody's got their talents and characteristics, so we're not like a herd of sheep you know. (Gina)

I think the way that they have tailored the treatment is ideal for me to explore what went on and try and reconcile myself to these things and plan for a better future. (Emily)

A vision of recovery that addressed the whole person's life thus appears to be incorporated into the treatment objective.

a) 2. Sharing Power

A constituent property of collaborative treatment was to involve patients in the treatment planning process. The sense of being included and consulted in this process appeared to pay respect towards the patients need to experience some sense of control whilst undergoing treatment, which Button and Warren (2001) and Eviors et al. (2003) emphasise as crucial.

Gina explains:

You get to see your consultant, and you can make suggestions. So you are very much part of the care plan...that's been very important...coz I don't like just being told what to do...Its really a 50/50 thing, we all compromise.
(Gina)

By being given the position of consultant within their own treatment plan, Gina shows how she is willing to “compromise”, indicating that the difficult challenges involved in undergoing treatment become acceptable and form part of the agreement by her own consent. Being consulted in the process of treatment-plan decisions was thus felt by patients to honour their right for autonomy, reflecting an ethos that not only demonstrated a basic respect for patients' need for human dignity, but showed an effort to balance out the inequality that inevitably exists between patients and staff:

They treat you on a human level, on an equal footing.... Nobody has ever approached me with an overbearing, authoritarian thing. It's always been on a level, like a peer group. (Helen)

They listen to what I have to say, they accommodate that. (Fiona)

It feels a lot more, individual, and there's a lot more, kind of respect...It's a breath of fresh air. (Gina)

These extracts show that in being treated “on a human level” the treatment context fosters non-coercive forms of relating in which patients “[no longer felt] forced to do things...[or felt] that treatment was punitive”. Herein, the struggle for control, so definitive of treatments founded upon a medical-model, was significantly diffused, and instead, the ‘struggle’ became focused on the patients’ own relationship with their ED rather than with staff.

Furthermore, by limiting the remit of control to behaviours that clearly related to the ED, treatments (re)constructed the notion of control as a specific and necessary protective mechanism, rather than an oppressive all-pervading contextual feature. Helen explained:

I think it is important that they take control away from food, but not everything. When they take control of everything its awful because you've just lost any sense of control in your life. I needed the control of what I eat, when I eat, taken away from me...Being able to do other things when I want to is really important. (Helen)

In delineating an arena of control designed to target and contain specific ED behaviours whilst respecting patient’s freedoms in other areas, the legitimacy for treatment to exert its authority was accepted on terms that made sense to patients and subsequently appreciated for the safety it offered (see also Reid et al, 2008).

Offering a collaborative approach also functioned as a constructive challenge to those participants who struggled with a sense of undeserving:

I need to be brave enough to tell them...what I want (Gina)

I really appreciate being treated more like an adult. I get to make my own decisions. I have become so much more, apparently, assertive. I am able to tell people when I am finding things difficult. (Fiona)

These extracts show that giving patients the power to ask for what they want - to voice their needs, their fears and their wishes - challenged patients to develop their skills of assertion that could enable them to take an active role in, and responsibility for, the treatment process. The value of “having a say” within patients’ treatment, repeatedly emphasised by participants, is shown here to address and confront a latent interpersonal pattern, reported by several participants, of acquiescing to others needs without considering their own, which was reported to obstruct their recovery.

The difficulty of granting oneself permission was identified as a key factor in the emergence of the illness, which imposed its control through prohibiting patients to “be able to do, be, say, have things”. Such self-denial referred not only to food, but to a wide number of phenomena associated with self-care, including warmth, physical comfort, relational contact, or the permission to enjoy oneself. In a very real sense, the importance of ‘gaining permission’ referred to claiming the right to live life. Whilst a sense of permission appeared to emerge, in part, as a by-product of regaining a sense of value as a human being, patients emphasised the necessity of receiving the message explicitly that they were being given the permission to eat.

I don't give myself permission. Here does. They're saying it's the right thing to do. That's the key. (Karen)

The therapist was like - 'You are allowed a packet of crisps if you want a packet of crisps, you are allowed it.' I was like, oh my god. Yes I am. It was a kind of like, a completely different approach. (Emily)

These excerpts show that treatments considered to hold a benign form of authority enabled patients to imbue staff with the power to give patients permission (see Appendix 24 for further discussion).

a) 3. Developing Trust: Enabling a therapeutic alliance.

Participants view of treatment as collaborative fostered their underlying capacity to trust the service as a whole and to cultivate the potential for developing a constructive and genuine therapeutic alliance with staff. Staff's consistent effort to establish communication with the 'actual person' enabled patients to trust that:

They were there for you, they were not there for your eating disorder.
(Anna)

I feel like they are helping me to get back, and they really really do mean the best for me. (Fiona)

Staff's genuine intentions towards the patient became visible to participants in sensing that

staff were not primarily interested in patient weight-gain, but were focused instead on understanding the difficulties creating and maintaining the eating disordered behaviour.

Feeling their “actual person” valued, patients own desire to recover from the illness was fostered and invited to form an alliance with the staff so that together they could tackle the ED. Cathy offered an insightful description of this dynamic:

There are some ways you cannot work collaboratively with an eating disorder patient, but there are other ways you definitely do. I don't know if this image helps: when I feel people are listening to me and helping me fight my illness with them and I'm on the right side of the fence, and my illness is on the other side and I feel so powerful and thrilled and grateful for that support and like, anything is possible. But then as soon as they make me feel that I've kind of done wrong, or I'm not succeeding at treatment or I can't trust them, I'm immediately thrown over to the other side and I'm stuck with my illness and they are on the other side, and I wanna be with them, but I can't be.

This account portrays ‘the illness’ as providing a defensive strategy against bad feelings, taking over the person when they feel threatened by others. Herein, it communicates the power of relationship in a patient’s recovery process. The experience of feeling supported and understood is seen here to provide the necessary framework and resources needed for the patient to fight against their illness. Geller’s (2001) research similarly emphasises that "a central component of therapeutic care is...to remain on the same side as the client, always" (p.370). This indicates that treatment approaches conceptualising the ED as a manifestation of psychic conflict demonstrate their understanding that patients feel tortured by the domineering nature of their ED on the one hand, and terrified of losing it on the other.

Subsequently, in contexts where trust felt possible, patients began to seek out support to negotiate the confusing and painful internal battle that arose, most powerfully, when having to confront their ED behaviours.

Collaboratively making decisions about the route of ‘progression’, participants commended treatments able to consider the patients limits when determining the pace of change. This had the positive effect of reducing the likelihood of dissociative or traumatised responses to feeling overwhelmed by treatment demands and to increase patients sense of safety in the process of change (also see de la Rie et al., 2006). Indeed, Karen expressed her appreciation towards treatment when reflecting upon the “gentle encouragement” she felt from staff within a service able to “offer the time [for her] to process things”. She explains:

I feel exceptionally lucky that I ended up here. That I’ve had the time here that I have, because there’s so much support here. It’s been a slow process. I’ve been allowed to feel my way. (Karen)

This excerpt presents the delicate process of supporting patients to progress in recovery according to a pace that allows them to digest change and navigate their own way forward. Fiona also emphasises the value of this:

They listen when I say I can’t do things, [or] all of these things at the same time. I’m finally starting to accept that weight-gain is part of recovery and I’ve never been able to say that before or even contemplate it. (Fiona)

By determining the speed of change according to patient’s ability to manage treatment demands, the service demonstrates their understanding that forcing change is

counterproductive. Communicating instead an attitude of patience, the service appears to cultivate the space for both patients and staff to attend to, ‘process’ and support patients ‘actual person’ in their effort to recover. This finding resonates with other studies (de la Rie et al., 2006; Keski-Rahkonen & Tozzi, 2005) emphasising the ‘crucial significance’ of “meeting clients at their own stage and awareness of pacing” (McInerney, 2014:23). Staff’s patience also signalled treatment’s dedication to honour patients’ autonomy within the treatment and recovery process, advocated also by Geller et al. (2001) as essential. In the effort to articulate why treatment felt ‘so much more personal’, Fiona explained:

Because it’s a voluntary unit. It’s not forced, they don’t force you to sit down and eat, [so] as much It’s not really your choice, it is your choice. (Fiona)

a) 4. Devolving Responsibility

Treatments successfully enabling patients’ to take progressively more ownership over their treatment was reiterated repeatedly across participants accounts as central to the recovery process.

The physical and mental weakness caused by starvation often led patients to seek protection from their ED upon arrival, since they “didn’t have the strength to fight”. Subsequent to this emergency phase however, it became crucial to devolve responsibility and power, gradually and in incremental stages, back to the patient to make their own choices and mistakes (also see Smith et al., 2016). In asking Fiona about the concept of control she replied:

*I think there are points when you need it (the control) to just be taken away.
And I think the first week, couple of weeks, when I’ve been in somewhere it’s*

enough to have it taken away. But there's times as well when I feel, if I don't take back some of the responsibility, I'm never gonna be able to take it back...I need to make my own mistakes. I need to do it myself basically. And luckily, they've been really accommodating about that, which is what is so different about [this clinic]. (Fiona)

Rather than infantilising patients in their position as ill and dependent, services providing a collaborative 'staged' approach actively supported patient capacities to develop their sense of competence and responsibility. Smith's (2016) study similarly found that "handing over control within treatment [signified]...a step towards restoring [patients] feelings of self-competency" (p.24). This process is seen in Danielle's account below, which describes the transformation emerging from staff's insistence that she harness her own agency in the recovery process:

We are not going to force feed you because it has to come from you." And that for me was the trick, the switch... I could have gone on for years if I'd gone to another hospital like that..[personal responsibility] was the hardest reality for me...It was the tough love that really got my head straight. (Danielle)

By "[feeling] as if the goals and objectives were [their] choice" patients began to understand the process of recovery as an act of empowering the 'real self' in which they were "doing it for themselves". Herein, staff stepped aside from the fight for control and directed patients to face their own power. Geller's (2001) work within ED treatment draws from exactly this principle. Emphatically asserting that "the client is responsible for change" she goes on to

explain that "by assuming a non-confrontational position, emphasising the client's choice in making decisions about her care, and placing the onus for movement and change on the client, the power and control issues typically encountered by both the clinician and client no longer occur" (Geller et al 2001:371-372). This, she continues, "open[s] the door to a different sort of relationship, in which the client has the opportunity to examine her problem with eating from a new perspective" (p.372). This relational stance appeared to help many participants in this study to question the utility of "[doing recovery] for other people" and to foster a self-driven motivation to get better.

Theme b) Experiencing Containment

The experience of treatment as a containing environment, where patients felt their ED was effectively managed, was another key property of constructive services. The creation of containment was achieved through several treatment characteristics, identified in 4 types of negotiation: ***b) 1. 'Providing Physical Safety' b) 2. Integrating Communication; b) 3. Relational Connection; b) 4. Non-punitive Control: 'Tough-love'.*** This theme is presented in figure 7.

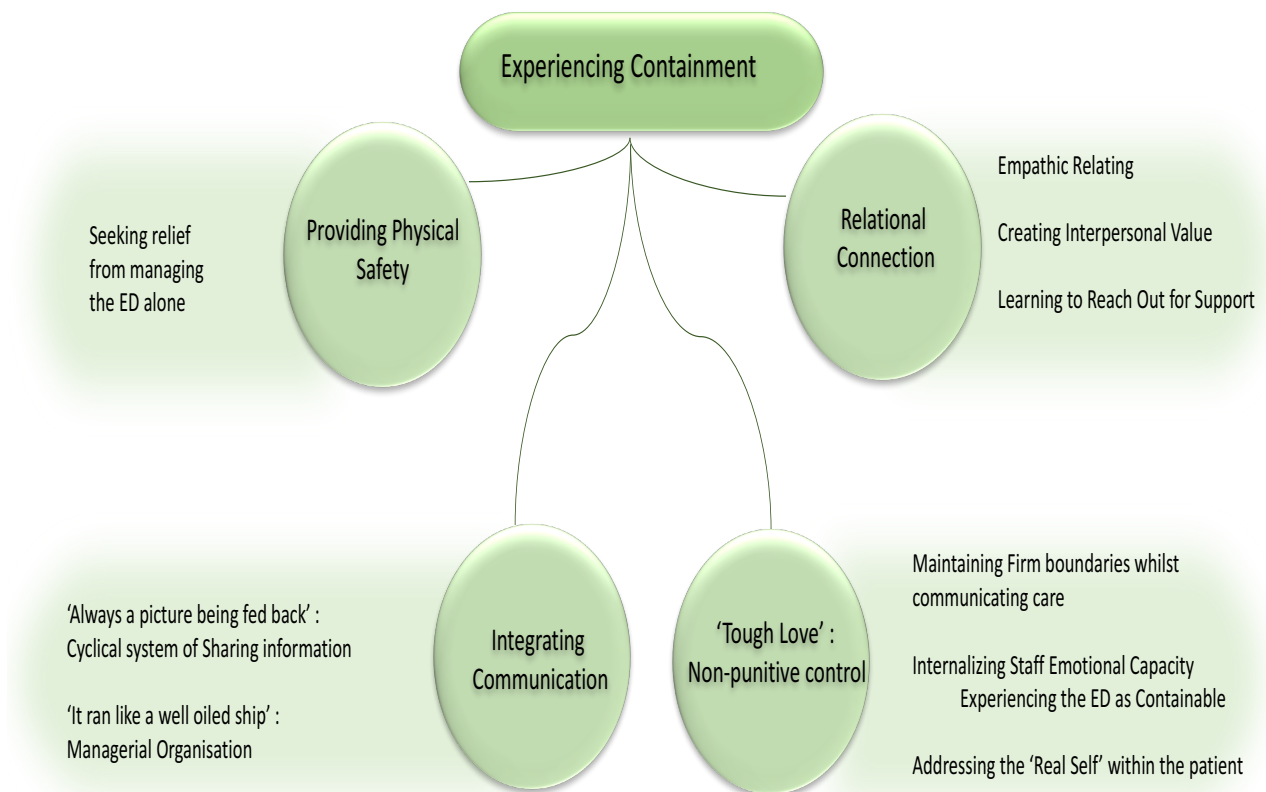


Fig. 7: Category B, Theme b), Experiencing Containment

b) 1. Providing Physical Safety

Some participants mentioned that the initial utility of being admitted to an inpatient clinic was in receiving physical protection at a critical moment when the constraints imposed by their ED had become unmanageable:

I knew that I needed to be put in a place... I wanted everybody else to do all my thinking for me.... I didn't want to have to try to manage this (Anna)

I felt like I was kind of being saved from myself in a way because I think my illness was really taking hold of everything...I felt this huge relief to be taken off the treadmill of the eating disorder trying to keep up with life (Cathy)

The role of residential services to take total control over the patient's medical condition by ensuring they receive sufficient nutrition to avert the risk of death and/or halt further degeneration was received by several participants with a deep sense of relief as they were becoming aware of having lost control of their ED behaviour and observing their physical demise without the physical or mental strength to fight against it. Such participants viewed the provision of physical containment as perhaps the most crucial act in the earliest stage of treatment. Viewing their admission as a form of respite from having to manage the 'mentalness' of the eating disorder on their own, these participants reported their willingness to "surrender" to "being looked after", allowing treatment to take full responsibility for the feeding process. This stage of inpatient treatment was referred to by one participant as "the honey-moon period", after which surrendering to treatment became a daily struggle.

b) 2. Integrating Communication.

Service structures that facilitated an integrated system of information-sharing were identified as a key property that enabled patients to feel emotionally contained whilst in treatment. Participants described the benefit of services structured to ensure staff were informed about the issues, challenges and goals of each patient. This type of information sharing was reported to be maintained by daily team meetings updating staff on patients' emotional process and progress. The cyclical nature of this communication system required "patient[s]

feedback to staff, [through] routines like the daily diary”, where patients would “comment on their day, good and bad, for therapists to read” creating a flow of reflective inquiry about the patient’s wellbeing, so there was “always a picture being fed back” to the patient. Within such services, patients viewed the treatment team as cohesive and concerned about patients’ internal experience, leading them to feel seen and contained. As Danielle stated;

There was this really really good communication... I didn't feel lost there.
(Danielle)

Generally, it's the whole team, just feeling like, right illness, there is nowhere for you to go, you are completely exposed, and this is how we're gonna move forwards altogether. There can't be any secrets...I hated that, everybody knowing everything, but I need water-tight containment, that kept you safe.
(Cathy)

Cathy’s account identifies how the sharing of information between staff generated a type of transparency that helped disable the power of the ED. Delivered with care and underpinned by patients’ trust in the service intension, the high level of observation became acceptable and constructive rather than intrusive and humiliating. Such effective systems of communication were also associated with a high staff-to-patient ratio and a high quality of managerial organisation, leading Emily to state with admiration:

‘It ran like a well-oiled ship’ (Emily)

This analysis support's Valenti's (2014) statement highlighting continuity of care as "an essential condition" (p.835) of good quality care, since patients in these environments appeared to feel 'known' by individual staff members and have the opportunity to develop personal relationships with them during their admission.

b) 3. Relational Connection

Providing empathic relational support was also central in facilitating patients towards recovery. As noted in Smith's (2016) study, the experience of being cared for by staff was intrinsic to patients emerging belief that they possessed the strength to change. Statements like "I couldn't have done it without them" abounded in accounts of constructive treatment experiences. Indeed, participants accounts of encountering kindness from staff were often very moving and seemed to indicate how accustomed they were to being treated with coldness.

The "personal quality of staff" was reported as an effect of seeing "staff enjoy[ing] their job", "sharing themselves and their time" generously and sensing that "you just know they want to be there". The value staff felt about their job seemed to help patients to grasp a sense of their *own* value and to view the treatment experience as a positive process, also found in Ramjan's (2003) study. As identified by Reid et al. (2008), perceptions of staff as generous with their time and emotionally available also helped patients feel safe enough to risk reaching out for support:

They are lovely here, the staff. They give you time freely. I used to be so scared of asking for help. (Gina)

It was just that kind of availability and support that's just like, incredible...being able to say "I'm struggling, I need help" - that is the really tough stuff. (Danielle)

The experience of “always hav[ing] somebody there to connect to” appeared to challenge patients habitual position of relational withdrawal and help participants to engage in meaningful dialogue in which they could access support to negotiate the internal conflicts arising from their ED. As Trepal et al. (2012) puts it, “instead of using disconnection strategies, they are encouraged to remain in connection” (p.352). Cockell et al. (2004) similarly identifies that “learning to reach out” and “feeling understood...prevented...[patients] from using their eating disorder to cope with difficulties” (p.530). Button and Warren (2001) conclude that “this ‘non-specific’ aspect of psychotherapy [may be] more important than formalised psychotherapy” (p.93; also see Hsu, Crisp, Callender, 1992). Validating these claims, services that encouraged patient bonding, laughter and play were hugely valued by participants, and in several cases fostered the development of a pro-recovery group identity in which patients gained self-value by supporting each other to getting better.

b) 4. Non-Punitive Control: “Tough-Love”

Experiencing the ED as an entity that would “[do] anything it could to survive”, patients inevitably resisted and tested treatment rules and regulations, demanding that staff impose firm boundaries. Emily explained:

“[Staff] challenge you a lot as well, which is what eating disorder people need, as far as I’m concerned...not told off, but they need somebody that’s firm” (Emily)

Being able to test [staff] and them being faithful and robust in their commitment to the person not the eating disorder. (Anna)

Staff’s capacity to maintain an attitude of care whilst holding treatment boundaries in place implicitly demonstrated that staff members were not overwhelmed by the emotional demands of managing patients attempting to act-out ED-related behaviours. Rather than vilanising or punishing the person consumed by their ED, participants described staff addressing the ‘real self’ within the patient, in reflections such as ‘you’re struggling at the moment’, which signified acknowledgement of the emotional strains that lay behind the ED behaviours. Participants’ subsequently discovered “that things didn’t have to turn into turmoil” or end up “feeling like a bad person” when overwhelmed by the ED. As Miller and Stiver (1997) state, in coming to “believe that another person(s) can be empathic and responsive to them” the patient could begin to develop self-empathy” (p.135). Staff’s emotional capacity was seen to be gradually internalised by patients, whereby they began to develop their own ability to contain and manage the ED.

c) A Place for Self-Development

‘A Place for Self-Development’ examines how a focus on psychological elements of patients’ wellbeing was developed and maintained within person-orientated services. This theme involved two types of negotiation: *c) 1. Differentiating self from Illness*, and *c) 2.*

Providing a full therapeutic program: ‘It’s the feelings not the food’, as summarised in figure 8.

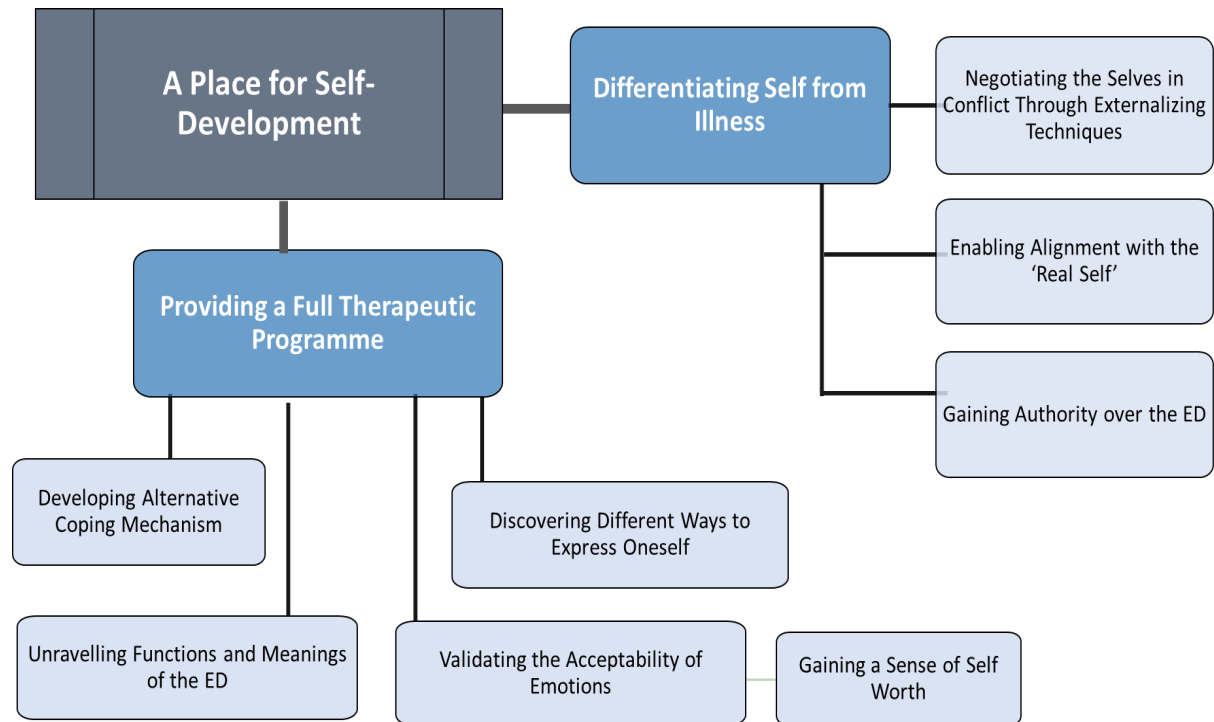


Fig. 8: Category B, Theme c) A Place for Self-Development

c) 1. Differentiating Self from Illness

Participant’s progression from viewing their ED as an indistinguishable part of themselves to conceiving that the ED and other parts of self were distinct and could be separated was described as a highly constructive process:

I feel so much better now, and I can recognize what’s an unhelpful thought. I can recognise what’s me and what’s the illness. (Julia)

A lot of the time when I've been suicidal it's not me. And they say don't kill yourself when you're within the first 5 years of recovery because you're not killing the right person. (Danielle)

In this account Danielle assumes treatment's perspective, which constructs 'the illness' as a force that destroys hope and obscures the 'real self's' desire to live life. Through applying a conceptual framework that constructed the ED and the 'real self' as separate and distinct, patients were powerfully enabled to create an internal sense of space to reflect on and negotiate their experience of internal conflict. Asking Helen how she related to the idea of recovery, she relied:

Being able to do things for me, rather than my eating disorder.

So you find it useful to differentiate between the illness and you? I respond.

Yeah. I find it really helpful because you can say it's the eating disorder that doesn't want you to eat, its bullying you. It's the eating disorder that's fighting for survival. So it kind of helps me fight it, because I'm not fighting myself, I'm fighting this foreign entity. Because having a fight with yourself doesn't work very well. (Helen)

By externalising 'the eating disorder', Helen's capacity to identify and maintain a position of opposition towards it was fortified. Tierney and Fox's (2010) study of the 'anorexic voice' supports this finding. They suggest that paying "attention to the anorexic voice during treatment may help to improve outcomes by supporting patients to gain control over it" (p.251). As seen in these excerpts, Tierney and Fox found that the "process of externalisation allows people to recognise and label their dysfunctional and dangerous thoughts as the 'voice

of the illness” (p.251, citing Kleifield, Wagner, Halmi, 1996).

Indeed, Daniele and Emily applied this conceptual framework with a clarity and authority that appeared enable a position of determination to stay aligned with the ‘actual person’ and to push forward with recovery:

It was almost like having this double existence of being...having this whole other section of myself where there was that loathing and self-destruction.
(Danielle)

I am fully aware now when it's me talking or when it's the eating disorder talking. Because I've got a relationship with it...where I can actually talk to her and tell her to fuck off. (Emily)

Tierney and Fox's (2010) therapeutic suggestion to use "role play" as a means of coaching the individual "to respond to their voice more assertively and [learn] to defend their right to be treated with respect and dignity" (p.251, citing Chin, Hayward, Drinnan, 2009) is presented in Emily's narrative. Furthermore, as her 'real self' increased in strength, her ability to negotiate and manage the ED became easier:

The more and more work I've done on myself, not Alexi [the Ed]...the more understanding of who I am and what I like, without Alexi, the quieter she's got and the more she is just, I don't need her as much...The less power she's got.
(Emily)

Emily here describes the process by which, attending to the ‘real self’ rather than the ED, she expands the dominance and power of her ‘actual person’ to subjugate the ED back under her control. This gradual shift in power, indicates that this distinction becomes increasingly consolidated as patients develop further along in their recovery. This process is depicted in *figure 9*.

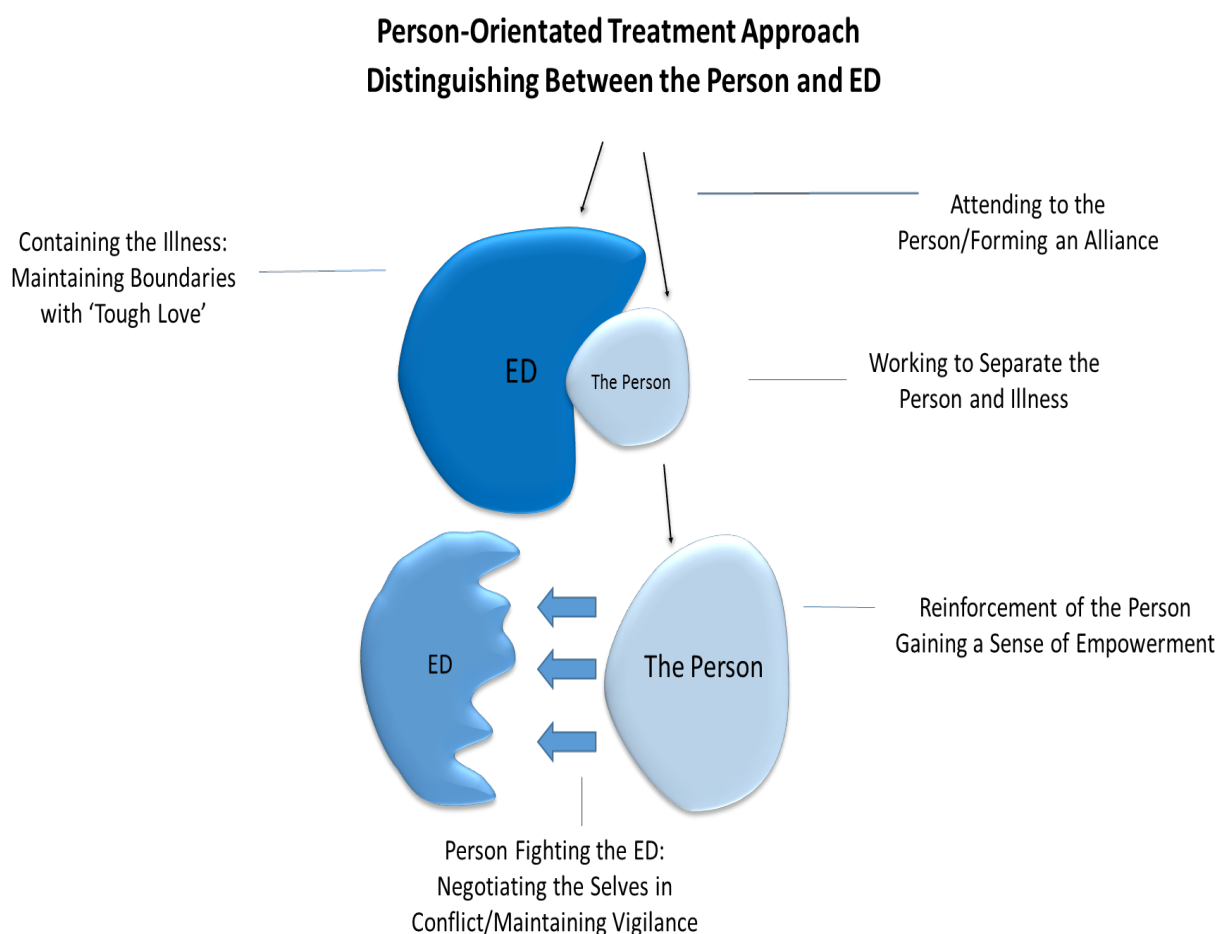


Fig. 9: The Process of Distinguishing Between the Person and ED within Person-Orientated services.

c) 2. Providing a Full Therapeutic Programme: ‘It’s the feelings not the food’

Providing an ‘intensive’ psychotherapeutic programme was found to be a central component of treatment enabling patients to develop an insightful and constructive relationship with themselves. Within contexts that provided therapeutic work as a full-time activity, meals were sometimes referred to as “what comes in between” therapy, indicating that the focus on eating was marginalised during the treatment process and centred instead around therapeutic work. Patients also remarked on the sense of structure and purpose they gained in being required to “work hard” throughout the week:

It’s the most powerful emotional raw thing I’ve ever sat through in my life.

(Emily)

Really intense. But brilliant. Exactly what I needed, despite me fighting it.

(Daniele)

The ‘rawness’ of undergoing an intensive psychotherapeutic program suggests an experience in which patients are laid bare in their vulnerability and made to feel alive through engaging with themselves and others in a meaningful way. In contexts offering a diverse range of therapeutic modalities, participants discovered different ways of expressing themselves, identifying particular relational modalities that best suited them:

I loved the drama therapy, really helpful...it made me want to get better. And it gradually changed the way I felt about my body. I’d always had problems with expressing myself, coz I didn’t have to word things, [but in drama

therapy] I didn't have to think about how I felt, didn't have to say...I could just do it. (Helen)

Cathy voiced how “incredible” she found equine therapy:

You can't pretend. [The horses] could see things weren't fine no matter how much you wanted to believe it. It was really like a mirror. (Cathy)

For me doing step work is the change. That what makes the change. (Danielle)

Participants described how psychotherapies helped them to unravel the functions, objectives and meanings associated with their ED behaviours (see also Geller et al. 2001, de la Rie, Noordenbos, Donker, Van Furth, 2008; McInerney, 2014; Tantillo, 2006; Trepal et al., 2012), as well as to develop the resources needed to protect themselves from ED thoughts.

Creating the safety and space to express feelings enabled patients to acknowledge difficulties and to receive from others acceptance and validation of their emotions. This experience was found to directly enhance Anna's sense of self-worth:

It took me a long time to acknowledge that I find things difficult...Having an accurate sense of what I was feeling...actually helped me develop a sense of worth. (Anna)

Actually giving my feelings a source, not just saying 'oh the food'. (Anna)

West's (2005) analysis of group work similarly found that "palpable attention and acknowledgement within the circle also gave rise to an experience of *worthiness*-that one's thoughts and feelings mattered and were legitimate" (p.105). Patients' development of relationality and experience of being supported appeared to displace their need of and dependence on ED behaviours by constituting and creating alternative coping mechanisms (also see Cockell et al., 2004; Le Grange & Gelman, 1998; Reid et al., 2008):

Being at [that clinic] gave me a way to deal...healthily with the feelings, which was absolutely mind blowing for me. (Anna)

You have all these wonderful groups where you challenge each other, and... you learn how you can cope with life. (Cathy)

d) Repositioning for Recovery

The Process of repositioning for recovery involved three types of negotiation: ***d) 1. Cultivating Hope; d) 2. 'Doing it for oneself'; d) 3. Establishing Self-Management Practices***, as presented in figure 10.

Repositioning for Recovery	Cultivating Hope	'Being believed in'
		Reconsidering the notion of 'readiness to recover'
	'Doing for oneself'	Individualizing the concept of 'recovery'
		'Building myself Up'
	Establishing self- management strategies	Cultivating self-honesty
		Developing cognitive and behavioural strategies
		Focusing on short-term goals

Fig. 10: Category B, Theme d) Repositioning for Recovery

d) 1. Cultivating Hope

For many if not most participants, the hope for recovery had previously been relinquished, having experienced many years suffering the ED, multiple experiences of relapse post-discharge, and experiences of treatment they felt to be personally damaging and ultimately engraining of their ED. Patients development of hope and sense of possibility about their own recovery therefore signified a valuable achievement emerging from constructive treatment experiences.

Patients' cultivation of hope appeared to be dependent on feeling others believed in their ability to recover. Being believed in thus appeared to underpin patients own hope and belief in the possibility of recovery (see Appendix 25 for further discussion).

The notion of 'readiness to recover', which pervades clinical literature on eating disorders, was also spoken of in interviews. Participants often expressed the need to be 'ready' for recovery before they could make use of treatment. Some patients spoke of the need to reach "rock bottom" and wondered whether they could have made better use of previous treatment admissions had they felt more willing to change. Analysis nevertheless indicated that patients' sense of 'readiness' appeared to be partly, if not largely, contingent on their treatment experiences:

If I hadn't come here I might have been one of those people who aren't ready to recover. (Karen)

[That treatment experience] made me really want something else, really want to be better. (Anna)

It was a game-changer. (Anna)

It gave me some idea of what recovery could be. (Anna)

Despite participants' acceptance of their individual responsibility, these accounts indicate that their desire for recovery developed in response to, and as a consequence of, positive treatment experiences. The process of becoming willing to relinquish their ED seemed to depend on its replacement with something better – a belief that their 'real self' could emerge and thrive. This involved a change of perception from viewing recovery as "enduring a living hell" (in which weight is gained but nothing else changes) to "seeing it wasn't about that". Patient's engagement in treatment here demands that recovery is constructed far "beyond the parameters of diagnostic criteria" (Malson et al., 2011:31), which conceives recovery as the mere absence of symptoms involving weight restoration and establishment of 'normal' eating behaviours. Instead patients presented a more fully realised, involved, creative and relational notion of recovery (also see Cockell et al., 2004; Garrett, 1996).

d) 2. 'Doing it for oneself'

Developing an individualised conception of what recovery could look like and identifying their own route through recovery was also a central property of repositioning for recovery. This involved underscoring patients' autonomy through determining their own pace and goals. Participants emphasised:

It's got to be in my own time. (Gina)

It's got to come from me. (Cathy)

This assertive self-positioning appeared to challenge several participants' habitual interpersonal style of living life to please others. Harnessing a sense of “doing it for oneself”, participants made efforts to prioritise their own needs and focus on “building [themselves] up”. This involved giving themselves the permission to feel good, affirming the legitimacy of one's needs and desires, working on interpersonal issues and reaching out for support

Establishing Self-Management Strategies

Participants described a variety of individually tailored cognitive and behavioural strategies they employed as a way of maintaining vigilance against the powerful pull of (re)engaging with the ED. As Anna summarised:

You are watched all the time (in treatment) and it teaches you to watch yourself. (Anna)

Many participants emphasised the importance of cultivating self-honesty in the process of engaging in recovery, interrogating their thoughts to identify the ED at work:

If you're not truthful, you're not gonna get there...coz this illness is very good at lying. (Karen)

Participants described how they managed guilt, challenged self-blame, self-destructive beliefs and counter-productive behaviours through developing protective behavioral strategies such as establishing a meditation or spiritual practice, developing self-affirmations and supportive mantras such as “*it's the feelings not the food*” to keep them focused and supported through

the day. One participant for instance described in detail how she developed a cognitive ‘trick’ that enabled her to delay gratifying the ED’s demands:

My illness gives me...soo many reasons why I can't have something. There's no point arguing with it, I can't win...so I trick myself (and) say. "Ok, I'll have breakfast but...I won't have eat dinner tonight...Ok dinner now, but I promise you I won't have night snack. At the moment I seem to be able to keep putting it off to the next thing." (Cathy)

Similarly, many participants explained that keeping a focus on the short-term goals helped prevent feeling overwhelmed by the long journey ahead. “Taking each day as it comes” constituted a tactic that supported participants to persevere with immediate challenges without having to carry the broader, bigger prospect of ‘full recovery’ at any one moment. This helped participants to manage feelings of ambivalence towards their recovery as well as to manage their expectations about change (also see Cockell, 2004). “Taking it each day as it comes” also appeared to help participants tolerate facing the many life losses that arose in their awareness as they began to acknowledge, recognise and let go of the illness (see also Tierney and Fox, 2010). These behavioural tactics provided strategies that strengthened their psychological reorientation towards recovery and helped patients to develop meaning in their experience of living in which it became possible to see change as a positive phenomena.

Figure 11. summarises the process occurring within person-orientated contexts:

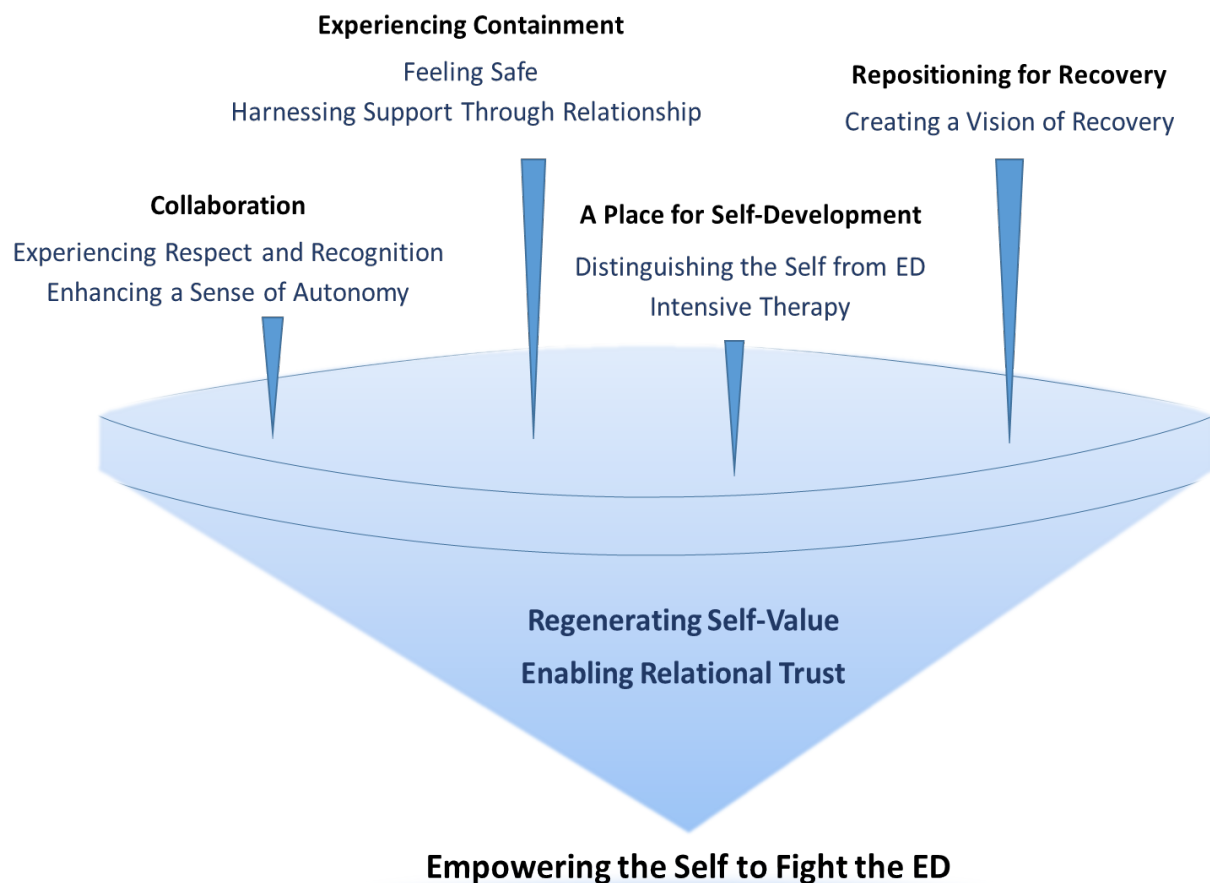


Figure 11: Model summarising Category B

Chapter 6: Discussion

‘Fighting for Survival’ presents the central finding of this study. In being admitted to an inpatient clinic on account of a ‘severe’, ‘enduring’ or ‘critical’ AN diagnosis, the nature and direction of a patient’s ‘fight for survival’ was found to manifest in vastly different directions according to their response to the particular treatment context in which they were situated. Mediated by a patient’s willingness or ability to trust a particular treatment setting, the patient’s ‘fight for survival’ appeared to be determined not necessarily by *what* treatments did, but by *how* treatment procedures were delivered. Studying the contextual and relational phenomena that gave form to these different responses from participants, analysis identified how the organisational systems and conceptual frameworks maintaining the treatment context influenced the nature and production of relationships between patients and staff.

Despite the variability between participants’ experiences of inpatient contexts and many participants’ experience of multiple admissions to several different services, their accounts depicted a divisive portrait of treatment services through the contrast emerging between their positive and negative experiences, which tended to be associated with distinctive types of treatment according to participants’ understanding of the treatment’s primary objective and therapeutic model.

Medicalisation: A Discourse of Resources

The most common types of treatment experienced by participants were identified with the more traditional and mainstream medical model paradigm of service provision. This identification emerged from participants’ observations that confirmed a service’s primary drive centred upon the agenda of ensuring patients gained weight efficiently and consistently. Such services tended to be run by the NHS, although not without several exemptions, such as

those funded by various means (eg. private, public organisation and NHS). Within these services, several participants within interview rationalised the reasons for a service's narrow clinical focus on patient's physicality, conjecturing that it was informed by organisational pressures arising from resource and funding constraints. These pressures were understood to shape the design of the clinical system, in which patients were processed into and out of the service efficiently, as a way, several participants explained, of managing the surplus demand for hospital beds. These findings appear to correspond with Breeze & Repper's (1998) study, in which nurses experienced pressure from the hospital system for patients' quick recovery. Similarly, Jarman's (1997) study reported nurses experience of feeling unable to meet the current demands on services. Adding to these findings, participants' accounts in this study indicated that the target-orientated nature by which patient progression was tracked and the numerical means by which these targets were measured, reflected a service culture that is primarily concerned with accountability for decisions of resource allocation, rather than what participants considered to be 'real' recovery outcomes for patients.

The application of standardised protocols and prioritisation of efficiency infer that medical model services have appropriated a discourse of resources whereby clinical care is predominantly conceived and described in terms of categorisation systems and numerical outcomes. Such a discourse is apparent in the website copy of one service discussed by a participant, where treatment offers "evidence-based care packages", "assessment, treatment and management" and asserts clinical aptitude to treat patients categorised as "severe and intractable" (NHS Foundation Trust, Eating Disorders Service, n.d). The site further states their primary intentions of inpatient treatment to be 1. Weight restoration, 2. Improved eating behaviours, 3. Reduction in compulsive eating behaviours and 4. Clarification of diagnosis, leaving the matter of social and psychological development at the bottom of their list. Another service, also referred to as a 'feeding clinic' by participants, defines their clinical

efficacy through a discourse of quantification based on patients' weight increase outcomes (see Appendix 26). This study found that such discourses shaped the interactional context within service delivery through processes of standardisation, pathologisation, and 'fast-tracking weight-gain'. The negative effect these processes were voiced by participants through fierce critique illuminating how they felt reduced to objects devoid of human validity and revealing how 'feeding clinics' inadvertently re-enacted the sense of alienation and disembodiment that participants described as central characteristics of their ED.

The Abjection of Emotion

Despite services' alleged intentions¹⁶, the pervasiveness of the medical paradigm appeared to displace staff's interest, or sense of need, to explore the meanings and functions of eating disordered behaviour. 'Feeding Clinic' contexts were consistently reported by participants to demonstrate little effort or ability to engage in meaningful dialogue with patients. This was found to foster in patients a persistent feeling of being misunderstood, neglected and judged negatively by staff. Previous studies have also raised concerns regarding the level of staff's understanding' of eating disorders in general and how to work effectively with AN patients specifically, identifying that this lack of knowledge damages staffs' ability to be sympathetic and produces a tendency to 'blame the patient' for their difficulties (Ramjan, 2003; Breeze & Repper, 1998; Jarman et al., 1997; King & Turner 2000). Whilst this study supports these findings, participants accounts also problematised the service protocol of employing temporary staff to provide nursing care (see Appendix 27 for further discussion). Furthermore, this study reinforces prior study findings highlighting how feeling 'misunderstood' features as a reason for patients reluctance to engage in treatment (Tierney 2008; Shattell, McAllister, Hogan, and Thomas, 2006; Colton & Pistrang, 2004; Cockell et

¹⁶ One website, identified as a 'feeding clinic' in this study states: "Our care and treatment addresses both the physical consequences of the service user's eating disorder, as well as the related underlying psychological and social factors" (Priory Group, Adult Eating Disorders Services, 2017, para. 3)

al., 2004; Button and Warren, 2001; Eviors et al., 2003). Supporting previous research findings, this study therefore proposes that the ways in which AN is currently being constructed and understood by care providers is of pressing concern and may require changes at an institutional level to address how practitioners currently apply discourse and models of care in treating AN patients.

Providing Psychotherapy within the Inpatient Context

The lack of psychotherapeutic provision, reported in this study to be characteristic within ‘feeding clinics’¹⁷, contributed to patients’ perception that the service and its staff considered their psychological wellbeing of little, or significantly less, concern than that of weight-restoration. Aside from the insult participants expressed in being deemed too cognitively impaired or mentally compromised to engage in dialogue that could meaningfully address the issues underlying their ED, the practice of deferring psychotherapy to a later stage (see Appendix 28 for further discussion) appeared to be understood as representative of treatment services inability to value patients as people, which undermined the possibility of developing constructive therapeutic relationships within these contexts.

This study therefore adds to Button and Warren (2001) finding that patients request individual therapy to be provided by ED treatment services, by proposing that the current provision of manualised CBT therapies are not adequate or sufficient to meet patients’ psychological needs within the inpatient context. This study therefore challenges traditional psychiatric opinion that individual psychotherapy is inappropriate for people within the inpatient setting, since this study has found that patients both desire and benefit from the opportunity to engage with a diversity of therapeutic approaches and methods.

¹⁷ Services were reported to deliver forms of CBT or psychoeducation via group and, in some cases, individual sessions. However, within ‘feeding clinics’, the impact of these therapies was reported to be negligible and even reprehensible, since participants often experienced these therapies as a process of being lectured at rather than engaged with. Moreover the hostile climate of such environments often appeared to render therapy provision ineffective.

The Continued focus on Weight, Food and Eating

One of the primary sources of a patient's alienation from and hostility towards the treatment process emerged from their understanding that a clinic's rehabilitative intention was focused almost exclusively on the physical components of their wellbeing (see also Button and Warren, 2001; Colton and Pistang, 2004). Participants in this study expressed bewilderment and angered objection towards services organising their treatment around food and weight. As identified in prior studies (eg. Gremillion 2002; Boughtwood & Halse, 2008; Reid et al., 2008; Malson et al, 2004; Eviors et al., 2003), the intense focus on the 're-feeding' of patients was felt by participants to exacerbate the symptomology of 'food and weight-focus' that clinicians were allegedly trying to eradicate. However, despite repeated recommendations that "the therapeutic agenda should not primarily emphasise the body, body-weight and eating" (Reid et al 2008:959), the present study findings indicate that such practices continue and the recommendations emerging from service-user research have failed to adequately inform and transform this feature of inpatient practice. This paper thus corroborates prior research by again attesting to the urgent need to review services focusing the treatment process on food, eating and body-weight.

A Culture of Rationing

Participants' critique of 'feeding clinic' services illuminated how the discursive, cultural and financial influences under which they operate seem to produce a social structure forced by the rationing of capital, exhibiting an anorectic approach to resources. This presents a metaphor for the problem itself in which patients, staff and the system alike are 'starved' of certain resources: Struggling under the pressure of oversubscribed clinics and pressure to meet targets, these services appear to 'ration out' the

resources considered most valuable to participants, inhibiting and marginalising the humane and relational elements of treatment that participants expressed a strong need for and were identified in this study as essential for a constructive treatment environment.

Supporting this, several participants emphatically voiced that the issue hindering the quality of treatment provision was not primarily a matter of financial limitation, but *how* financial resources were used. These participants' expressed that NHS services appeared to have ample financial resources but failed to invest in the relational dimensions of treatment provision, and instead allocated financial resources in systems and personnel pertaining to medical management. Non-NHS and Private clinic's adopting a medical model approach (with apparently adequate financial resources) were therefore criticised on a similar basis, where again, the treatment agenda was felt to be driven according to service needs rather than the needs of patients, and whereby body-management practices were persistently prioritised over and above other therapeutic interests or issues.

Regarding the financial resourcing of 'person-orientated' services, all were private-sector organisations, funded by a range of sources including private, insurance, and local authority grants. Of these services, three were based (to differing extents) upon a 12 step-approach and one upon a definitively person-centred philosophy. The three 12-step based services appeared to proffer from a financial affluence that distinguished them from the rest, as indicated by the wide variety of therapeutic provision and high staff/patient ratio. In the person-centred service, where six participants were interviewed, financial resources and the scope of therapeutic provisions were clearly more limited. Yet despite this disparity of financial resource between person-orientated services, participants' evaluations were found to be of similar value within the data. The major source of qualitative difference between all services therefore appeared to be predominantly founded not on scope of financial resources

per se, but on a service's philosophy and the sense of relational wealth that participants felt within a particular treatment environment.

Humanisation: A Discourse of 'personhood', Resources of 'Time' and 'Social Capital'

Within 'person-orientated' services for instance, the resource of 'time' appeared to be prioritised. This manifested most notably in participants experience of staff¹⁸ as able to be physically and emotionally available to individual patients, for hours if necessary. Such capacity appeared to be founded upon, and attenuated to, service investment in developing a culture rich in social capital, whereby staff were resourced by a treatment's organisational system through being sufficiently supported to manage the complex emotional demands of their job as well as to create and maintain a sense of value in their role. This was found to affect the interactional context between staff/patient relations, transmitting to participants' a sense of value towards the treatment process and themselves. These treatment characteristics suggest the existence of a prevailing discourse of 'personhood' which is reflected in their service description on their website¹⁹.

Cultivating a Sense of Human Value

Resulting from this person-orientated ethos, participants reported how they were treated and related to as a human being, rather than as a subject defined by their pathology. This quality was found to facilitate patients' development of trust towards a service in which they subsequently felt able to risk sharing their vulnerability and draw on staff/patient

¹⁸ Within this study, I have applied the term 'staff' as a unitary category to refer to any personnel including nurses, therapists, psychiatrists and managers working directly with patients in the inpatient context. This study therefore does not distinguish between different types of care providers. Nevertheless, accounts tended to discuss interactions with nursing staff being the people with whom patients spent most time.

¹⁹ One person-orientated service's discussed in this study copy presents relational outcomes as primary on their website, stating: "We offer patients... 1. a philosophy based on a person-centred approach 2. a calm, optimistic environment within a climate of honesty and openness, 3. a programme designed to reinstate both physical and psychological well-being, 4. the opportunity to explore and rediscover a sense of identity" (Newmarket House, n.d, para 3).

relationships to access support. Subsequently patients' need for the ED was tentatively replaced with the ability to experience interpersonal forms of connection by which to manage feelings of distress and recover a sense of personal value worth living for. This emphasis on ethos rather than specific therapeutic procedures corroborate previous studies that identify patients' tendency to "[focus] on the impact of the 'therapeutic milieu' rather than treatment content" (Smith et al., 2016:24) and Wright's (2010) similar proposition that "therapeutic relationships seem to be more about a way of being rather than doing" (p.159; also see Shipton, 2004).

Respect and Validation

Associated with this apparent appreciation for patients' fundamental humanity, staffs' attitude of 'respect' towards patients was found to be central in creating and maintaining the therapeutic alliance. The quality of 'respect' involved participants feeling that they were listened to, taken seriously and their experience validated as understandable. The process of 'validation' appeared to be contingent on locating the meaning of patients' ED behaviours within a framework outside of pathological assumptions where staff were willing to understand the condition from the patient's perspective and to recognise the unique manifestations of their difficulties and dilemmas. The value of this clinical perspective has similarly been identified in de la Rie's (2008) and Tierney's (2008) studies. Furthermore, Laing's formulation of the therapeutic process seems to resonate with these findings. He declares: "the psychiatrist is...not treating a disease; rather, he/she is validating a diagnosis made by the patient about "normal" life and assisting the patient in her attempts to be healed of it." (Laing, 1967:125) These findings also support Laing's proposition that the "treatment" the patient most desperately requires involves fellowship, communion, a relationship with

another human being in which his humanness is acknowledged and respected” (Vice, 1992:128).

Investing in Psychotherapeutic Provision

The positive effects of these qualities appeared to blossom within services that provided a programme of intensive and meaningful therapeutic group-work in which participants felt supported to develop a sense of self-acceptance and personal insight along with various behavioural and cognitive skills that equipped them to negotiate with, and defend themselves against, their ED. The opportunity to engage in multiple forms of psychotherapeutic practice was found to resource patients to cope with difficult feelings without relying on ED behaviours to manage. Crucially, patients (re)discovered a sense of connection which helped to empower aspects of their ‘real self’ to emerge and grow. This finding resonates with a central tenet of the Relational Cultural Theory approach which asserts that growth occurs in and through relationships and connections with others (Trepal et al., 2012; West, 2005; Jordan, 2010) and considers mutual empathy and mutual empowerment as necessary to help ED patients “work through the intense denial, ambivalence, and fear that keep them stuck in the early stages of change” (Tantillo, 2001:203). Despite the fear and pain arising from the process of ‘reconnecting’, participants appeared to deeply appreciate treatments that helped them to do this. Furthermore, these experiences of connection and trustworthy relational support provided the emotional containment they needed to feel safe within treatment, despite the terror of facing their ED.

The Importance of a Collaborative Ethos

A collaborative approach to treatment, in which patients were enabled to take an active role in their treatment and participate in the ongoing development of their treatment plan was also

central to their recovery orientated alliance with staff, as found in Colton & Pistrang's (2004) study. Treatments designing individualised treatment plans in collaboration with the patient lead to relevant treatment objectives that addressed not merely food consumption issues, but also the specific and unique fears underlying or surrounding a patient's particular eating practices.

Conversely, participants sense of exclusion from the treatment planning and decision processes within 'feeding clinics' constituted a central issue of contention and was understood by participants as an outright confirmation of the institutions systematic devaluation of the patient's voice and apparent lack of concern to harness or negotiate a consensual agreement from the patient upon which to administer treatment. It is possible that the medical model's construction of the patient as 'too ill' to be trusted with decision-making power discursively condoned their denial of patients' choice within the treatment process. Additionally however, the managerial meetings in which patients' treatment plans were reviewed (commonly referred to as CPA's²⁰), whilst often granted attendance, were not felt to amount to the opportunity to make meaningful contributions regarding treatment decisions. Participants' therefore felt silenced and voiceless within such treatment systems. This contributed to the emergence of a social norm characterised by relational disengagement and the generation of overwhelming and/or enraging feelings of powerlessness across accounts.

The Issue of Autonomy

A treatment's ability to support the development of a collaborative alliance with a patient relates to the notion of autonomy. Several studies have previously highlighted the importance of acknowledging and accommodating patient's autonomy in the treatment process (Reid et al., 2008; Eviors et al., 2003; Valenti et al., 2014; Malson et al., 2004; Gremillion, 2002;

²⁰ CPA stands for Care Program Approach.

Entwistle, Carter, Cribb, McCaffery, 2010; Smith et al., 2016) and problematised services ‘paternalistic’ attitude to patients (Valenti et al, 2014). In discussing participants claim for ‘autonomy’ however, I denote not ‘independence’ per se, as I view ‘the self’ as relationally constituted and thus inherently interdependent, but propose that “even in the ethically challenging context of involuntary treatment, there are possibilities to increase patient freedoms, enhance their sense of safety and convey respect" (Valenti (2014:832). Entwistle et al. (2010) provide a relational view of autonomy which greatly enriches this concept as it can be applied to the inpatient context where autonomy of decision-making may be unviable owing to the patient’s high risk of mortality, status of detention under the Mental Health Act (1983) or may only marginally retain their ‘voluntary’ status on the condition of treatment compliance. Entwistle et al. (2010) emphasise that all communication with patients [can be] potentially significant for their autonomy, and that any interaction or social influence can be autonomy-supporting or autonomy-undermining according to whether treatment restricts self-development skills and undermines self-evaluations, or enhances them. This perspective suggests that efforts to empower the patient through any variety of social influence or therapeutic interaction may be a valid and sufficient means of supporting patients’ capacity for autonomy within the inpatient context.

As discussed, patient’s ability to experience a sense of choice about their treatment goals appeared to be an essential component of a patient’s willingness to take personal responsibility within treatment and to engage in the process of personal change founded upon their own volition. A collaborative approach to service provision thus seemed to communicate sensitivity towards issues of power and disempowerment on an operational level.

On an interactional level, participants experienced the collaborative ethos through recognising staff’s concerted effort to negotiate the power differential existing between them

by adopting a manner of 'being on a level' and sharing power with clients. Data also indicated that staff's competence in negotiating issues of authority with patients was associated with services that minimised hierarchal structures between staff members. This finding corresponds to Wright's (2010) assertion that "the intrinsic institutional power relationship must be considered if the patient is to take on an equal and reciprocal position within the therapeutic relationship" (p.157). These features, amongst those discussed previously, indicate that the collaborative ethos of 'person-orientated' services considerably enhanced patients' autonomy capacities.

Conversely, a patient's sense of exclusion from treatment planning within 'feeding clinics' appeared to establish a social order in which treatment proceeded without patient consent. This was found to consolidate the patients' perspective of treatment as a coercive regime and to destroy the foundation upon which any valid 'recovery' process could occur.

Patients "reduced desire to cooperate" on account of viewing staff as 'dictatorial' in their approach or experiencing treatments as punishing and disempowering has been identified in previous studies (eg. Colton and Pistrang, 2004; Ramjan, 2004; Ryan et al, 2006; Long et al 2012). Uniquely however, my study conceived patients strategies of resistance as a means by which patients attempted to reclaim some semblance of personal autonomy within contexts where it was felt to be denied. Challenging the established view that issues of authority and control in ED treatment arise from AN patients' pathological need for self-control (Bruch, 1978; Lawrence, 1979; Lask and Bryant-Waugh, 2000), this analysis suggests that patients view the ability to maintain some sense of autonomy and self-agency as a basic human need. This perspective is supported by Eviors et al. (2003), who write that "the desire to have control, to negotiate the boundaries between autonomy and dependence, is a general feature of human relationships. In this sense the thoughts and

feelings that underlie even the most extreme coping strategies, may be, in themselves, extremely ordinary” (p.104 citing Warner, 2000).

The Implications of Patients Disempowerment

This acknowledgement of a patient’s need for autonomy-supportive interventions is further reinforced by the implications of disempowerment found in this study, whereby patients signalled their high sense of psychological threat in suffering intense states of stress, fear, and (post)traumatic symptoms. Considering this further, it is important to recognise how the experience of ‘powerlessness’ or of ‘lacking control’ appears to signify a prominent etiological feature in those developing eating disordered symptomology (Bordo, 1993; Bruch, 1973; Button, 1993; Slade, 1982). Participants within this study consistently described powerlessness as a facet upon which their ED ‘fed’, explaining how the ED behaviours mitigated feelings of powerlessness by enabling the person to regain a feeling of control over their body, mind and emotions through the medium of food. Thus, as Eviors et al. (2003) suggest, “by re-invoking feelings of powerlessness” treatment may “inadvertently contribute to the maintenance of behaviour they ostensibly wish to change” (p.102). Whilst Eviors’s findings were associated to patient’s decision to ‘drop out’ of treatment, this study found the impact of feeling powerless deepened patients’ internal identification with their ED even whilst remaining an inpatient where they were denied control over food and weight.

Treatments framing a patient’s desire for control as an expression of their frightening internal experience of disempowerment within their lives, alongside a view of a patient’s need for control as understandable and legitimate, corresponds with feminist perspectives of eating disorders, which are viewed as arising from a lack of control, power and autonomy in patriarchal society (Bordo, 1993; Orbach, 2006). Such theory proposes that females need to feel empowered in areas of their life other than eating or weight to be able to fully recover

from their eating disorder (Clarke, n.d). The integration of such a perspective into treatment practice is likely to encourage patients to explore and reflect upon their need for control as a socially, rather than merely individually, derived facet of their psyche. By ‘de-centring’ the issue of power and control outside of their individual psychology, patients may be better facilitated to consider how their experience of disempowerment emerges from social conditions within their lives. Such a perspective may therefore help to create space within the therapeutic process to identify or develop alternative and more self-enhancing resources for (re)gaining a sense of power and control in their lives.

In referring specifically to issues of female disempowerment, I recognise this study fails to represent the male, non-binary or trans-gender sufferer of AN. Having recruited only female participants for interview, this study is unable to develop insight regarding how a person of a different gender may inform social interactions within the inpatient context. The absence of non-female participants in this study however also exemplifies the low representation of non-female groups within AN inpatient services. Whilst instances of AN are fewer in non-female, non-white populations and therefore less likely to require inpatient care, the predominance of white females within AN inpatient settings may indicate that sufferers falling outside of this demographic are less likely to be diagnosed with AN. Indeed, psychiatric descriptions of AN reflects a heavily gendered presentation which is likely to have perpetuated its ‘discovery’ in females, thus reproducing the female AN inpatient as a clinical category and supporting the reproduction of services that are culturally adapted to a white, female population.

Dis-ordered Treatment

Participants’ view of treatment as a system of ‘reward and punishment’ was found to present a striking parallel to their descriptions of the ED itself. Participants often described

how their ED existed as an internal punishment/reward system, leading them to deprive themselves of kindness, comfort or nourishment in various forms. Treatment thus appeared to symbolise for patients an enactment and externalisation of their self-punishment and self-deprivation by mirroring the ‘techniques’ that their ED used to coerce the patient into submission to its control. Treatment itself became ‘the authoritarian controller’ of the patient and appeared to replace (or displace temporarily) the ED by offering a social manifestation of the ED entity itself. Further reflecting treatment’s re-enactment of ED characteristics, participants experience of staff as inflicting punishment for exhibiting ‘ill’ or ‘resistant’ behaviours was found to reinforce internal feelings of ‘badness’ within themselves, which the ED was reported to both manage and reproduce.

A Battle for Control

Participants perception of mutual feelings of hostility between patients and staff echoes previous studies that identify a “struggle for control” (Ramjan, 2004:498; Long et al., 2012:246) within inpatient contexts and the cultivation of a culture symbolically structured by “‘us’ and ‘them’” (Long et al., 2012:246; King & Turner 2000). Such dynamics have previously been understood to constitute a 'major obstacle to developing therapeutic relationships' between patients and staff” (Ryan et al., 2006:132; Marks, 2000; Newell, 2004; Ramjan, 2004; Colton and Pistrang, 2004; Long et al., 2012; Ramjan, 2004). In this study also, the establishment of antagonistic relational dynamics in which both patients and staff became ridged and oppositional was found to generate ‘reactive’ behaviours in which staffs’ focus on behavioural control became paramount and patients held on to their ED mentality and behaviour as if for life.

Strategies of Resistance

‘Compliance’ to treatment within this study was found to constitute one of the most common forms of resistance employed by patients. Unlike previous studies, which employ the term ‘compliance’ to constitute a positive indication of a patients’ engagement with the treatment process, my analysis found that compliance and resistance existed in the same bracket of symbolic signification. The appearance of complying and engaging with treatment was often discussed by participants as a conscious strategy to be discharged from treatment as quickly as possible. This position was reported to require “shutting down all instincts” indicating a profound ‘dis-connection’ from the body alongside a willingness to sacrifice their bodies up to treatments control. Meanwhile, patients described concealing or withholding of some aspect of their self-identity as ‘outside’ and ‘against’ the treatment’s authority in what seemed to be a primal attempt at self-protection of their intrinsic sense of self-hood. Patients’ position of ‘compliance’ towards treatment thus signified a means by which they could negotiate a dualistic positioning of self between their internal experience (cohering a position of withdrawal and rejection of treatment) and external presentation (of conceding and consent to treatment). The ‘success’ of this strategy appears to be achieved by subverting treatment’s tactics of control into patients own self-management practices, which effectively locates treatment failure on account of defining AN as a condition determined by weight-status.

The strategy of ‘force-feeding’ themselves was understood to symbolise a more explicit and aggressive expression of a patients distain towards a treatment experienced as violating and ineffective. By taking the role of brutalisation upon themselves, this form of resistance performatively demonstrated the violence feeding clinics were felt to inflict, whilst again flaunting the futility of a treatment’s weight-gain’ agenda by showing that the ED was no less powerful in spite of weight-gain. Staff’s awareness or lack of awareness of the

signification of this resistance appeared to be of little importance to patients except to inform their view of staff as either ‘cruel’ or ‘clueless’.

Participants’ report of shedding the weight-gained within treatment upon discharge appeared to represent a desperate attempt to expunge the “horror” of their inpatient experiences and re-assert ownership over a violated body. Loss of weight post-discharge therefore seemed to reveal how “feeding clinics” reinforced patients conception of food as a mechanism of control alongside their use of food as a means of expressing anger toward being controlled by others.

This analysis suggests that institutions’ appropriation of control over patients’ bodies led participants to reassert the ED as the central means by which to re-claim and re-establish their self-agency and sense of psychic safety. Treatments ultimate ‘failure’ was therefore located in the consolidation of the patients’ pre-existing system of self-management dependent on ED strategies.

Resistance Reconsidered

Previous research has conceived patients ‘resistance to treatment’ either as an inherent characteristic of AN, or as part of an internal conflict (Cockell, et al, 2004) in which AN sufferers take up “multiple, shifting, ambiguous and contradictory subject positions in relation to their diagnosis, to the prospect of change and to their treatment” (Malson et al., 2004:480). Whilst recognising this latter aspect of ED symptomology, this study expands current understandings of ‘resistance to treatment’ by examining such behaviour in terms of their symbolic meanings pertaining to negatively experienced treatment contexts.

Having identified contextual factors that increase the likelihood of patients (re)alignment with their ED, this study enhances our understanding of the adaptive value of eating symptomatology as a strategy of self-protection and demonstration of anger in the face

of perceiving themselves detained within a threatening and devalidating social environment. This study therefore illuminates how adverse social influences and interactions can reinforce a patient's view of the ED as essential for their survival as defined by the need to maintain a sense of autonomy in the world.

The Disembodied Self

This study's examination of patients' resistance strategies identifies how patients' draw on their pre-established 'ED' capacity to disconnect from their embodied experience (in order to feign 'engagement' in treatment and gain weight) by inhabiting a 'disembodied self'. Patient's negotiation of self in this way presents a form of rigid mind/body dualism that reproduces cultural dichotomies of male/mind/reason over female/body/impulse (Gremillion, 1992; Malson, 1998). This dualism is also understood to be central to the epistemology of psychiatric discourse (Gremillion, 1992). Through reproducing an ideological split between mind and body, the medical model framework itself appears to facilitate patients' re-establishment of their 'disembodied self', which Bordo (1992) conceived to be a primary role and function of the ED condition.

This analysis is consolidated by the way patients discredited the validity of a medical approach by demonstrating their ability to both tenaciously adhere to treatment demands whilst manifesting their ED strategy in the extreme. Patients acts of resistance thus reveal and reproduce psychiatry's core values of control over mind and body as illness. As Gremillion (1992) articulates: "the anorectic literally embodies objectivity as control" revealing that AN patients "are themselves enmired in the forms of domination that their illness disrupts and challenges" (p.58). This presents the practice of anorectic behaviour as a penetrating "challenge [to] psychiatric epistemology as well as the social milieu in which both illness and explanation are embedded" (p.58).

A Socially Critical Treatment Model

To address this ideological pitfall, treatments taking a critical perspective towards cultural norms including contemporary constructions of femininity, sexuality and power may help to generate a treatment culture that challenges the values patients draw from to reinforce an ‘eating disordered’ response to their environment. Treatments with the capacity to support inter-dependence, connection, and embodiment as ‘ways of being’ may help to validate and expand aspects of the patients’ phenomenological experience that are commonly denied or distorted within modern society. This approach is likely to challenge patients’ adaptation to normative social pressures and instead support a socially resistant or dissonant position if a patient finds that their own means of self-growth require them to inhabit an alternative ideological or social space.

Differential Meanings of Control

Despite the common objective between all inpatient services to control patients eating disordered behaviour and their similar means of achieving this, such as maintaining high levels of surveillance, disallowing patients to participate in certain activities and ensuring patients consume substantial quantities of food, these rules were perceived by participants entirely differently according to the different meanings they held within a particular context. In ‘feeding clinic’ contexts, rules were overwhelmingly experienced as a means of subjugating, coercing or punishing patients. In person-orientated contexts, treatments’ controlling function was described positive terms: ‘rules’ were viewed as the protective means by which patients were prevented from ‘acting out’ their ED. In short, participants accounts displayed an appreciation for control by treatment when, and only when, it was delivered in a context where patients trusted that the treatment was well-intending towards them. When delivered with ‘tough love’, staff’s ‘control’ was spoken of in highly

complementary terms owing to staff's dedicated effort to re-establish contact with 'the person' in the face of a patients barrage of hostile behaviour and defensive posturing.

Staffs' Capacity to Work with Negative Emotion and Anger

Participants perception that the staff could cope with their negative emotions and anger without retaliating appeared to constitute a central healing experience. Previous research has indicated that anger may be an important emotion to understand in eating disorders, particularly AN (e.g., Fox, 2009; Fox & Harrison, 2008; Waller, Babbs, Milligan, Meyer, Ohanian, Leung, 2003). My findings support this proposition and identified ways that patients anger can be worked with constructively. Staff's ability to view these events as 'an ED attack' and to 'see' the patients 'real self' despite the patients' own failure to do so, was found to both sustain the therapeutic alliance and weaken the ED's grip. Adding to this, I suggest that staff's ability to confront and engage with a patient's feelings or expressions of anger may be greatly enabled by constructing anger as a source and resource of a patient's strength, resilience and power, which can be harnessed, taken back and reclaimed by the 'real self' - to fight the ED. This perspective concurrently utilises the functional value of the ED entity whilst also helping the patient to separate from it and to regain power over it. Such a construction of anger and resistance is likely to both support patients' ability to recover and to strengthen the therapeutic relationship.

Having had to face a life-threatening ED myself, I can attest to the personal utility of this approach: by harnessing the anger and aggression that was feeding the ED, I re-claimed it for my 'real self' and directed it back onto and against the illness²¹. This constituted a powerful force that propelled me forward in the direction of recovery. As Fassino & Abbate-

²¹ Please note that I adopt the terminology formulated from data analysis although I did not conceive of my internal experience in this way at the time of my own recovery process.

Daga (2013) stated: “an innovative approach to psychiatry should encourage patients to use their own resources to change” (p.3).

Distinguishing Self from ED

As implicated in the use of discourse throughout the study, a central study finding pertained to the powerful utility of constructing patients emotional, cognitive and behavioural difficulties in terms of a conflict between their ‘real self’ (or selves) and their ‘ED’. Services that implicitly adopted and communicated a multiple-self model of psychic functioning through conceptualising the ED as a distinct entity of the self was thus found to be a powerful tool that helped patients, as well as staff, to negotiate the complexity and conflict arising from confronting ED related feelings and behaviours. As Eivors et al. (2003) previously concluded from her study: ‘one of our aims in therapy [should be] to enhance a sense of self apart from that defined by the eating behaviours’ (p.104; also see Smith et al., 2016). By externalising the ED, staff helped patients to align with their ‘real selves’ and to reclaim a valid internal position. This finding supports Tierney and Fox’s (2010) proposition that creating “psychological distance between self and AN is required for recovery to transpire” (p.251, citing Higbed & Fox, 2010).

‘Feeding clinic’ services, on the other hand, were found to apply a discourse within treatment that reflected a predominantly essentialised and unitary notion of the patient’s ‘self’. This indicated an ideological orientation, common within modern Western cultures, towards understanding personhood predominantly in terms of an “individualised and unitary interiority of psychological attributes and characteristics”, which “remains largely stable across the various spatio-temporal contexts a person inhabits” (Malson et al., 2011:29 citing: Hall, 1996; Henriques, Hollway, Urwin, Venn, & Walkerdine, 1998). This construction of ‘the self’ was demonstrated to patients through staff’s lack of distinction between their

perceptions of pathological and non-pathological traits or behaviours of the patient. This symbolic interaction lead staff to conflate the ‘AN illness’ with patients ‘actual person’ or ‘personality’ whereby participant’s ‘anorexia’ became “constituted as an essential defining feature of the individual's reified 'self’” (Malson et al., 2011:30).

Counterproductively, this construction of the patient as (essentially) pathological produced an insidious effect whereby patients internalised this perspective, generating the belief that the anorexia “is just who I am”, or in which the ED entity ultimately engulfed the other dimensions of a patient’s self. As discussed by Malson et al., (2011), the full incorporation of this ‘anorexic’ role results in a self-position whereby “recovery for oneself, however desirable...comes to appear virtually unimaginable” (p.32) since the space for change and transformation within the self becomes closed off. Figure 9. presents a visual portrait of these different frameworks.

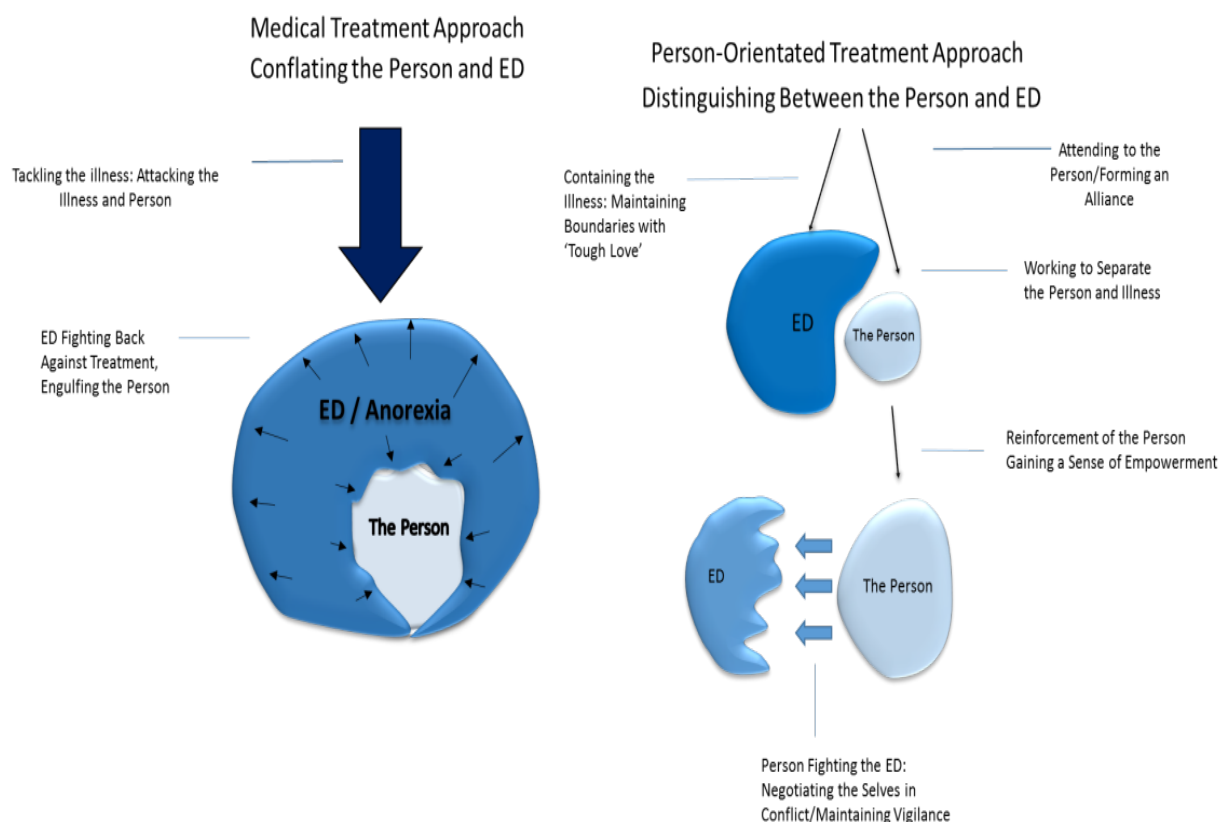


Fig. 9: Comparison of 'Feeding Clinic' and Person-Orientated Approaches to Treating the AN Patient.

Despite participants self-acknowledged difficulty of distinguishing the ED as separate from themselves, they were consistent and clear in their objection to this (re)instatement of self as essentially pathological. Meanwhile, all participants were highly receptive to contexts that helped them to untangle and distinguish different parts of the self that could be identified and related to as separate from, and in conflict with, this internal ED entity.

Participants' challenge of applying this conceptual framework to their internal experience was evident and they acknowledged their reliance on staff to help them. Transmission of this perspective was identified in a variety of strategies both direct, such as addressing the 'actual person' when talking to the patient in a moment of feeling overwhelmed by their ED, and indirect, such as treating the patient with a kindness and empathic interest that created the relational safety for the patient to explore their experience of internal conflict.

Whilst previous research has identified the possible value of "allowing separation from the 'anorexic' identity" (Winston et al., 2012 cited in Smith et al., 2016:25), literature has tended to frame this process as a way of 'strengthen[ing] the emergence of self-identity" (Smith et al., 2016:25). This study suggests that the pre-existence of other self-identities cannot be presumed to be undeveloped or non-existent, but that the ED entity, in its self-abusive impact, constitutes an imposition that gradually destroys and undermines the validity or living-existence of other aspects of the self: as the ED-self grows and intensifies, it increasingly 'takes hold' of the person, 'eating them up' both physically and mentally. Thus, alongside this psychic takeover, other aspects of the self recede in power and prominence. From this perspective, the ED is conceptualised as a disembodied, parasitic entity that alienates the person from other aspects of themselves, from other people, and often from wider life-activities or concerns. This construction of the ED corresponds with Tierney and Fox's (2010) study that identified ED sufferers thought of their AN in terms of an external

voice that “criticised and belittled an individual's actions, attacked her sense of self, made her question her own abilities...slated her as a failure and undermined her self-esteem and confidence" (p.249-250). In the current study, adoption of a multiple-self model of the psyche thus appeared to significantly support a patient in negotiating the confusing internal conflict emerging as patients confronting an ED, as well as to enable staff to step aside from the fight for control.

Recognising Staff Skills Specific

The common perception of ED nursing care as a form of ‘non-specific’ support, requiring ‘non-specific skills’ (McIntosh et al., 2004) thus appears to undermine the complexity of therapeutic skills and level of psychological understanding needed to deliver the type of support AN patients require. As mentioned, previous studies have highlighted the relational challenges for staff caring for AN patients. Long’s (2012) study for instance warned that “new staff could...quite eas[ily] fall into a confrontational pattern” with patients. Reid et al (2008) also purports that “staff lacking the specialist expertise...may alienate sufferers, even with slight and passing remarks or behaviours." (p.960; also see McInerney, 2014; McNamara, 1982; Tierney, 2008; Gellar et al., 2001). These findings support previous studies stressing “the importance of providing sufficient resourcing and training to facilitate the development and maintenance of positive therapeutic relationships with these complex patients" (Ryan et. al., 2006:131; see also Ramjan, 2004; Long et al., 2012; Jarman et al., 1997; Geller, 2001; NICE, 2004; Reid et al., 2010).

Staff’s ability to create a sense of emotional containment for the patient by maintaining firm boundaries without losing an attitude of care towards the patient, not only appeared to rest on specific skills, knowledge and attitudes of individual staff. The overarching service structure that supported staff with sufficient supervision and freedom of

time was understood to hold this approach in place. Geller et al (2001) also identified this. She states: "Staying on the same side is difficult, requires practice, and can be hampered by program expectations and policies" (p.371). Within this study, services driven by external targets and outcome initiatives corresponded to staff/patient relations defined by antagonism and conflict. By contrast, effective staff/patient relationships were found to exist within services where staff-member appeared to feel supported and resourced by the treatment organisation to provide effective care.

Theoretical Reflections

Maintaining the notion of a ‘Real self’ alongside a Multiple-self model of the Psyche

The notion of a ‘real self’ represented a term frequently used by participants (interchangeably with ‘actual person’) as a symbolic means of articulating their internal negotiations of self when confronting their ED. Findings simultaneously identified the benefit of adopting a multiple-self model. This may appear to present a philosophical contradiction and to create theoretical discord, since the ‘multiple-self’ theory of the psyche (Bromberg, 1996) emerged as a challenge to the preceding psychoanalytic view of the psyche as containing a ‘core self’ (Kohut, 1971). Findings suggest however that these constructions of self appear to operate advantageously together within the inpatient context. As discussed, participants’ notion of having a ‘real self’ appeared to carry pragmatic appeal by providing a linguistic device that enabled them to conceptualise and realise ‘non-ill’ aspects of self, which were discursively constructed as being more ‘real’ or ‘substantial’ than their ED-self, and which were associated to a primary sensation that inspired a desire to live (Winnicott, 1971). By implication, this constructs the ED-self as being ‘less real’ or ‘more false’ and is likely to have supported patients construction of the ED as an entity that was not of their own, but intruding upon the self and ultimately, despite its positive values and functions, driving them towards death. In this sense, the ‘real self’ was maintained as just one part of the multiple-self system, whilst locating it as more valuable and true to patients’ potential for living.

The ‘Split’ in the Study Findings

This study’s separation between person-orientated and ‘feeding clinic’ services represents a general split in participants’ accounts regarding positive and negative treatment experiences. In strict and definitive terms, this is theoretically problematic since patients and were found

to have a discerning view of positive and negative features existing within the same context. Additionally, it is possible, and perhaps common, that patients' may respond differently (positively or negatively) to the same treatment intervention. This study may therefore be criticised for simplifying the interactive context and complications of working with patients in these contexts, as well as for overlooking a patients' ability to hold both a positive and negative perspective towards the same treatment context/provider, which Colton and Pistang's (2004) study examines in some detail. Consequently, the present study may be viewed as reproducing an idealised or demonised view of the therapeutic relationship, which has been identified as a characteristic of people with eating disorders. Pemberton and Fox's (2013) research for instance identifies patients tendency to represent staff "as being extremely good, or terribly (verging on morally) bad, with expectations of care being idealised and perfect" (p.235). The authors interpreted this as to be a reflection of the AN individual's "perfectionism" considered to be "a key characteristic in their personalities" (Pemberton & Fox 2013:235; also see Treasure et al., 2006) and thus patients' negative judgements about a service or staff member were "inevitabl[e]" (p.235). I shall address these issues in several ways.

Firstly, the proposition that participants' distinction between positive and negative treatment experiences arises from 'perfectionist' and/or 'black and white' thinking, risks undermining how the real experiential effects of different environments, interactional encounters and treatment approaches can seriously affect both a person's ability to engage in treatment and their recovery trajectory. Rosenvinge & Klusmeier (2000) also point out the distorting potential of this interpretive angle, where "negative treatment experiences may be ignored as superficial [by the clinician or researcher] due to the [patient's] symptom denial and failure to recognize the need for treatment" (p.294). Research focusing analysis on how AN patients are insurmountably difficult and demanding are more likely to overlook the

issues existing in treatment practices that contribute to patients feelings of negativity and resistance. Thus, whilst conceding to the view that people severely ill with AN tend to be very sensitive to the behaviour of others, and acknowledging that this places a great demand on care providers, I nevertheless maintain that the inpatient context specialising in AN is responsible for developing a treatment approach, and interpersonal skills therein, to support an empathic understanding towards patients emotional experiences and contend that these analyses endorse a pejorative pathological view of the patient that have unconstructive effects on therapeutic care and inhibit reflexivity in clinical practice.

Secondly, the division between positive and negative experiences within the organisation of my theory is further accounted for through the research focus and angle of enquiry. My study is unique in attending to patients' experiences gathered from a multitude of different treatment contexts. Many of the participants had been admitted to several different services and were therefore in the position to be able to compare and contrast their experiences of treatment. Alongside this, my interview questioning was directed towards their views of treatment rather than focusing on their personal experience of internal conflict, which was implicitly understood to exist under any circumstances when facing this condition. Participants accounts both explicitly and implicitly showed that problems existing in person-orientated services could be overlooked because the central intention and mass-effect of its qualities were positive. Faults and issues were identified, but were evaluated as negligible and typical of any organism because, as one participant stated, "nowhere is going to be perfect, let's face it". Similarly, in 'feeding clinic' contexts, participants' were able to point out, for instance, that some staff were kind. The positive effects of such encounters however were found to be overwhelmingly outweighed by the amalgam of negative service characteristics. These issues and discrepancies were integrated into the resulting grounded theory by locating what the participant sought, such as the opportunity to take greater

responsibility for eating, into the model of constructive/person-orientated treatment, even if one service identified as ‘person-orientated’ had failed a patient in this regard.

Thirdly, participants’ capacity for reflective thinking about their experiences of treatment practices during interview appeared to be enabled by distinguishing the ED and their self. Participants seemed to assume the voice of their ‘real self’ when talking to me, perhaps assisted by the way I clearly recognised their ‘actual person’ and addressed them in terms of their personhood rather than viewing them through the prism of an AN diagnosis. Regardless of its cause, participants were certainly able to acknowledge their conflict with staff when struggling with their ED without condemning the service as a whole. And, where total condemnation was voiced, a multitude of reasons contributed to the making of these judgements.

Defining Services as ‘Person-Orientated’

During the early stages of analysis I understood participants narratives of constructive treatment contexts to be underpinned by a humanistic ethos and approach. This led me to reflect upon the philosophical roots of individualism underpinning humanistic theory. Feminist authors undertaking socio-political analyses have explored how eating disorder issues may be informed by individualistic values, which encourage a person to strive for individual perfection or improvement, be competitive with other individuals and seek ‘self-actualisation’ by attaining individual control over their life, self and body. Issues such as isolation, self-castigation, feelings of inferiority, inadequacy and distrust of others present the shadow side of an individualistic ideology, and represent some of the negative elements of self-relationship that people suffering with eating disorders are known to experience.

Humanism’s proposal that a person’s personal growth and ‘recovery’ lies in enabling them to become an independent individual, with independence or autonomy defined as fully

distinct from connectedness with others, identifies how the humanist paradigm separates a person's psychology from social processes. Such a philosophy stands contrary to the methodology underpinning this research, which maintains a relational view of human psychology in which individuals and societies are conceived as constituting each other in a fundamentally reciprocal process. The philosophy of individualism also contradicts the findings of this study which identify the benefit of a relational approach to understanding ED symptomology and recovery. Furthermore, my findings resonate with Gremillion's (1992) assertion that "the anorectic is a living criticism of the norm of ridged individualism with her isolated, rebellious, and rejecting stance" (p.63). This led me to question the utility of a humanistic paradigm as a means to challenge the roots of eating disorder issues since it risks reinforcing an individualistic ideological framework that arguably inform patients initial development and maintenance of an eating disorder (also see Malson, 1998).

My decision to re-frame some services as 'person-orientated' rather than 'humanistic', not only enabled me to maintain qualities typically associated with humanistic values, such as sharing power with patients, encouraging responsibility and fostering self-volition. It also provided a broader categorical scope able to account for services adopting multiple therapeutic approaches, and who may have questioned this identification with humanism. Moreover, viewing these services as 'person-orientated' helped to highlight how they differed from 'model-orientated' services, reflected in treatments' designed according to medical and behavioural modalities of illness or dysfunction, rather than patients' specific needs or views of reality.

Study Limitations

Use of Psychiatric Discourse within this Study

In referring to ‘the ED’ throughout the analysis and discussion chapters, I have aimed to avoid reproducing the category ‘anorexia/ic’ as a social artefact. The term also reflects my commitment to adopt participants’ own means of conceptualising their experience: some participants endowed their ED with a given name, such as ‘Alexi’, other’s called it ‘my/the ED’ and others referred to it as ‘my/the illness’. However, the term ED is short for ‘eating disorder’ and thus derivative of a psychiatric label. Indeed, elsewhere in the study I have frequently used the term ‘eating disorder’ directly and felt it necessary to use the term ‘anorexia’ to discuss the phenomena within the context, current and historical, by which it tends to be referred. I am therefore implicated in the continued use of medical discourse within this study.

This study’s apparent critique of medical discourse alongside my use of the term ED/eating disorder or ‘AN’ therefore represents a discursive dilemma, reflecting a tension previously identified in feminist texts that fail to break with existing theories of eating issues by continuing to use medical language and its attendant individualisation of social issues (Hepworth, 1999). “Referring to women as ‘anorexics’ is an effect of this discourse and argued to reproduce the position of women as subjects within that discourse” (Hepworth, 1999:58). Nevertheless, in staying faithful to participants’ realities, this study identifies how treatment contexts of all varieties are found to impart to patients a psychiatric framework by which to understand themselves, albeit to demonstrably different extents and effects. Person-orientated services however appear to have found ways of modifying this discourse to provide creative and constructive ways to support patients working to reshape their identity. That said, the dilemma remains and I consider it very possible that an entirely different

symbolic framework may yet to be generated that could be ultimately more beneficial for patients working to recover from personal difficulties with living that are expressed through issues with eating and food.

Context specific

Findings in this study are considered provisional rather than definitive since both the accounts themselves and my analysis of them are context-specific (see Parker & Burman, 1993; Foucault, 1977) and may be particular to a 21st Century British milieu in which both participants and I are located. This contextual positioning may be evident for instance in my choice of language, such the labelling of analytic categories, themes and concepts that reflect current trends in psychological discourse: the notions of agency, empowerment, trust, safety and empathy in particular reflect a contemporary symbolic framework and discourse by which Counselling Psychologists are taught to think about therapeutic work and signify valued qualities we are encouraged to create in our relationships with clients. The discourse adopted in this study therefore reflects developments in the field of psychology emerging in the 1950s and 60s across the US and Europe, when and where counselling psychology emerged as a field.

Further locating the research context, this study is based on a small number of adults with a wide variability of treatment experience. With two exceptions, all treatment services referred to clinics within the UK. I am therefore cautious in seeking to generalise from such a small scale qualitative study and do not assume the theory developed here to be directly transferable to the treatment AN patients in a different culture.

Theoretical Sampling

Utilising the method of convenience sampling to gain access to participants, it was necessary to interview six participants (Fiona, Gina, Helen, Iris, Julie, Karen) on the same day. This circumstance meant I violated traditional theoretical sampling principles in the data collection of these last six interviews, since there was no time to undertake constant comparison analysis between them. Whilst I mitigated the effect of this by allowing interview questions to be guided by themes I picked up in previous interviews during the day, I was unable to carry out an in-depth and systematic analysis between these interviews which would have helped me to identify gaps in the data and develop specific interview questions relevant to expanding, validating and saturating newly emerging concepts and categories in the latter half of the data collection process.

Examining Patient to Patient Interactions

The thesis produced from this study did not develop theoretical categories specifically relating to interactions amongst patients within the inpatient setting. There are several reasons for this. Firstly, limited data was gathered in this area owing to the aim of the study to focus on patients' perspective of service delivery. The information elicited during interview therefore tended to revolve around participants experiences of the institutional context and their relations with staff. Information pertaining to their relationships with fellow patients referred to during interview therefore did not constitute a central finding of this study. Nevertheless, participants did mention how their relationships with fellow patients affected their treatment experiences and data regarding these interactions were generated. This data helped to facilitate theoretical saturation of themes and categories, expanding our understanding of how specific treatment qualities within inpatient contexts effected the relational environment. This is demonstrated, for instance, in the category *Experiencing*

Connection, where data analysis identified how patients' ability to share and explore their experiences together through therapeutic group work was actively cultivated within treatment environments where patients personal development was understood to be a central aim of the treatment and recovery process. The category *Experiencing Connection* also identified the value participants placed on sharing laughter and a sense of playfulness amongst each other in contributing to a positive treatment environment that supported their openness to, and ability to bear, the recovery process. Conversely, within treatment environments experienced as coercive and punitive, several participants mentioned how a sense of group camaraderie developed amongst patients as a means of fortifying their resistance to and/or resilience towards their location within the institutional setting. This study therefore demonstrates how different patterns of patient to patient interactions emerge in the context of different inpatient services and contribute to the development of unique relational environments that significantly affect patients' recovery process. Further research however could examine this interactional arena more specifically with the aim to identify how, and under what conditions, patients' relationships with each other affect the impact of their treatment experience.

Summary of Findings

This study aimed to explore the experiences of adult patients experiences of inpatient treatment from a variety of different contexts, highlighting how various aspects of treatment delivery impact a patient's engagement with treatment and recovery prognosis. Uniquely, this study has been able to identify how different approaches to service delivery and care provision were associated with different outcomes for patients' in terms of their openness and sense of ability to recover.

Resulting from differences of service ethos and approach, participants cultivated vastly different personal conceptions regarding the purpose of treatment, what recovery involved, and the role of relationship within this process.

Within 'feeding clinic's', participants understood the purpose of treatment and 'recovery' as a physical process of weight-restoration, and their relationship with staff as a mechanism by which treatment achieved this objective. Patients objection to this process led to the establishment of a relational dynamic between patients and staff characterised by distrust, withdrawal and hostility such that staff/patient interactions were experienced to have a degenerative effect on a patient's sense of self. This manifested in patients' 'fight for survival' directed against the treatment context itself by manifesting a variety of resistance strategies aiming to subvert the treatment process, but which concurrently embedded their ED symptoms and 'anorexic' identity.

Conversely, within person-orientated services, the purpose of treatment and concept of recovery was conceived in more psychological terms, whereby participants viewed the treatment context as supporting patients to empower themselves by regaining authority over their ED. These services' evident focus on developing consensual and robust therapeutic

relationships appeared to produce an effect whereby patients felt enabled and resourced to begin fighting against the illness in the direction of recovery.

Study Findings In Relation To Previous Literature

This study has identified many of the difficulties, challenges and issues arising within inpatient treatment found in previous research, including patient dissatisfaction (Malson et al., 2004; Grilo & Mitchell, 2010; Valenti et al., 2014), resistance to treatment (Vitousek et al. 1998; Fairburn, Shafran, Cooper, 1999) and difficulties of the staff/patient relationship (Garrett, 1991; Grothaus, 1998; Kaplan & Garfinkel, 1999; King & Turner, 2000; Ramjan, 2003; Ryan et al., 2006; Geller, 2001). The application of GT methodology and comparative examination across multiple inpatient services from the patients' perspective however has enabled this research to extend, and sometimes challenge, our current understanding of such issues, uniquely identifying how institutional features of strategy and structure contribute to the development of the inpatient environment and effect the relational and interactional field of treatment delivery. Below I shall detail how the findings of this thesis support or contradict previous literature.

The study's theoretical conclusion that a service's philosophical approach to care, illness and recovery is of greater import than the application of specific therapeutic procedures in regard to the overall impact of treatment on patients presents an implicit challenge to a wide spectrum of literature focusing its research on the outcomes of specific therapeutic modalities, procedures or initiatives (Brockmeyer, Friederich & Schmidt, 2018; Watson & Bulik, 2013). This study instead indicates inpatient treatment would benefit from greater clinical and research emphasis on examining service ethos, organisational procedures and service-wide use of discourse.

On the other hand, this study supports and extends a wide body of literature advocating the utility of relational approaches to the therapeutic process (Wright, 2010; de la Rie, 2008; Tierney, 2008; Smith et al., 2016). By examining the value of a relational therapeutic method within a context where patients are commonly treated according to a medical, psychiatric perspective (due their categorisation as pathologically ‘extreme’, ‘severe’ or ‘enduring’) this research challenges the implicit presumption that relational approaches are unfit or insufficient for such a client group. The present study uniquely details how specific relational properties and conditions produce a sufficient and constructive inpatient environment that enable patients (often considered severe and intractable) to experience safety, support and to begin facing the possibility of their own recovery. Similarly, this study shows how a strong and coherent person-orientated ethos of care can support the provision of the high level of emotional & physical containment needed for this client group, whilst more traditional approaches (heavily influenced by a medical approach to AN) were found to fail in this regard.

This study also revealed that patients positive or negative response to inpatient treatments function to control patient behaviour varies according to their understanding of a services treatment intention towards them (see Differential Meanings of Control, p.159). This finding challenges previous literature reporting that issues of control within inpatient treatment for AN emerge on account of patients ‘pathological need for control’ (Lask & Bryant-Waugh, 2000; Lawrence, 1979; Bruch, 1978), presenting instead the necessity of a relationally analytic perspective in which matters of power, control and autonomy are negotiated by staff with considerable awareness and sensitivity. Indeed, the ‘battle for control’, widely identified across the literature as common to this clinical setting, was found to be significantly overcome in this study through the application of a collaborative approach. Extending Gellar’s (Gellar et al., 2001) work in this area, the collaborative

approach was found to be successfully achieved through procedures whereby patients treatment plans are individually designed and tailored to meet their specific needs, and patients capacities for developing and exercising autonomy were consistently enhanced through patient/staff interactions in which patients choices and judgment were consulted as part of any decision-making or conflict-resolution process. This challenges literature presenting coercive control as a necessary, and therefore consistently justifiable, means of ensuring patients ‘comply’ with treatment requirements.

This study also presents a challenge to literature which uncritically adopts a definition of AN according to the weight-status of a person, showing how this definition of AN has a negative, even detrimental, impact on treatment, such as exacerbating patients/staff conflict over control and cultivating (rather than diminishing) patients concern about weight. The study also problematises literature presenting weight-based definitions of recovery, instead supporting literature (eg Malson et al, 2011; Hardin, 2003; Orbach, 1993) that advocates a broad and holistic conception of recovery. Adding to this, the finding that inpatients both desire and benefit from the opportunity to engage in a diversity of therapeutic approaches and methods challenges traditional psychiatric opinion that individual psychotherapy is inappropriate for people categorised as severely underweight (see Appendix 28). Instead, it indicates that further research of services providing a range of creative therapeutic modalities for this client group would extend current understanding of effective treatment.

The study’s detailed exploration of the meanings and motivations behind patients resistance to treatment also derived findings that challenge prior literature’s enduring construction of ‘resistance to treatment’ as an inherent feature of AN pathology (Vitousek et al., 1998; Fairburn et al., 1999), instead supporting suggestions that resistance to treatment emerges as a product of problematic power-relations between care providers and patients

(Malson, 2004; Geller et al., 2001; Eivor, 2003). Uniquely, this study contradicts previous literature conceptualising compliance as an indicator of patient engagement in treatment (Ziser, Resmark, Giel, Becker, Stuber, Zipfel & Junne, 2018; Towell, Woodford, Reid, Rooney, Towell, 2001; Cameron, 1996; Steiner, Mazer, & Litt, 1990;), presenting compliance instead as a common strategy of resistance. The in-depth examination of this strategy demonstrated a highly concerning situation in which patient compliance engendered damaging levels of self-compromise and relational deceit as a means to be discharged from a negatively experienced inpatient environment. This suggests that services encouraging patient compliance is problematic (ethically and strategically) and is likely to be counterproductive for long-term recovery outcomes.

Finally, this study supports literature documenting the powerful utility of distinguishing the ‘Self’ from the ‘ED’ (Tierney & Fox, 2010; Kleifield et al., 1996; Chin et al., 2009; Higbed & Fox, 2010). This conceptual framework displaces the common belief that patients need to demonstrate ‘readiness to recover’ for inpatient treatment to be of any benefit, since the framework constructs sufferers difficulties in terms generating dual or multiple selves that are in conflict and contradiction. It is therefore to be expected that the ED self will fight for its survival, not wanting to recover, whilst another part of the self *is* desiring of recovery. This study finds that treatment can therefore offer potential benefit to any ED sufferer by facilitating their process of self-negotiation and providing a supportive environment in which their non-ED related ‘selves’ are fostered.

Responding to calls from previous research to increase understanding for patient dissatisfaction with treatment, (Newton et al., 1993; Rosenvinge & Klusmeier, 2000; Yager et al, 1989; Ryan et al, 2006) this study provided unique insight into the structural and systematic processes of service provision that generated pejorative perceptions of treatment as authoritarian, pathologising and coercive. Extending this further, treatments experienced

as ‘dissatisfying’ were found to re-enact a variety of features identified by patients as definitive of their ED, such as exacerbating feelings of powerlessness, experiencing the treatment environment as a regime of reward and punishment and facilitating patients’ re-establishment of their ‘disembodied self’. These ‘dissatisfactions’ were consistently associated in this study with treatments understood to centralise the re-feeding process as the main objective of inpatient treatment. This raises serious concerns about the continued manifestation and delivery of this type of treatment.

Study Implications

Reinforcing previous research, this study finds that patients’ genuine treatment engagement and ability to form constructive therapeutic alliances with staff members depends on their trust of both the service and staff regarding its humane view of the patient and holistic conception of recovery. Throughout the discussion of my findings, I have proposed several recommendations that may contribute to the future development of inpatient treatment provision for patients diagnosed with AN. My findings suggest that many services would benefit from a revision of treatment ethos and approach. The study proposes the adoption of a person-orientated approach to care in which the principle of collaborative practice is centralised and places the empowerment of patients as a priority within the service agenda. My study finds that this can be achieved through a variety of means, which I shall list below:

1. Inpatient treatments support a patients’ capacities for autonomy by enhancing self-development and self-evaluation skills. This was found to be enabled by providing a full and diverse programme of psychotherapeutic work, both group and individual. Findings also indicate the benefit of offering individual psychotherapy to all patients regardless of their weight status for the full duration of their admission and that a range of therapeutic

modalities be available, including person-centred and psychodynamic approaches that are informed by the principles of Relational Cultural Theory.

2. The study highlights the importance of resourcing individual staff to develop skills, both attitudinal and technical, that increase a reflective and curious attitude towards patients' experiences and difficulties. In support of this, it is suggested that inpatient services appropriate a discursive framework that minimise a pathological understanding of a patient's problem and instead foster insight towards the meanings latent within a patient's ED symptomology.

2. Findings support systematic efforts to minimise a focus on food, eating and body-weight within treatment delivery. This was found to be achieved within services that placed their focus on the psychological and emotional aspects of a patient's experience and difficulties.

3. Findings suggest services prioritise the allocation of resources towards internal communication systems to strengthen the coherence and delivery of the service ethos and approach.

4. Findings propose that structures of hierarchy within the treatment system are minimised and nursing staff are valued as centrally important deliverers of care, corroborating Ryan et al's (2006) study recommendation.

5. Findings suggest that services incorporate a multiple-self model of the psyche to facilitate staffs' ability to adequately and sensitively distinguish between patient and ED behaviours, thoughts and feelings. These demands personnel in managerial roles acknowledge the specific and advanced therapeutic skills needed for staff to be able to manage and work effectively with patients' hostile or self-destructive emotion.

6. The study recommends that services incorporate a critical approach towards cultural pressures that undermine or disempower women and girls. This may include

proactive means that enable patients and staff to engage in analysis of gender relations within society, the application of feminist theory to critically analyse popular culture, and the support of a socially resistant attitude in helping patients to reposition themselves towards recovery.

Conclusively, this study demonstrates the value of research examining patients' perspectives as a source of data that can significantly contribute to knowledge of inpatient treatment practices and their future development. This study is unique in representing the patients' perspective on the basis of their status as a human being, rather than interpreting the data in view of participants' medical profile or pathological characteristics. This analytic perspective has overlooked these patient variables with the intention to gain insight into issues affecting treatment effectiveness and efficacy without relying on patients' characteristics (such as severity or longevity of the illness) to account for treatment failure. This has aimed to identify qualities regarding treatment delivery that proffer positive results despite a patient's complex present condition or psychiatric history. I believe my dual role as ex-patient and practitioner has supported this angle of enquiry by allowing me to get close enough for participants to express their feelings freely and to read the voices of patients with the seriousness they deserve.

A final contribution this research makes to the eating disorder literature is to illustrate the value of qualitative methodological approaches for clinically oriented research. The study's insights regarding the impact of treatment culture and organisation on patient/staff interactions demonstrates the specific utility of GT methods to researchers wishing to capture an understanding of the influence of social context on individual experiences.

Suggestions for Future Research

This study suggests several avenues for future research. In the objective to advance the knowledge of effective treatment practices for AN patients, future research may benefit from examining clinician perspectives regarding the organisational, administrative and cultural influences on their work with patients within inpatient settings. Further understanding of the impact of service pressures to produce particular outcomes, meet targets, and the influences informing decisions of financial resources and service approach would complement these study findings and expand insight regarding how properties of context and culture affect the management and delivery of inpatient services. Inpatient services may also benefit from research examining clinician perspectives regarding their scope and freedom to work therapeutically with patients, examining how hierarchical structures are felt to affect their role within the service and their relations with patients. Additionally, further examination of the relationship between policy documents pertaining to service aims, agendas priorities and practical application of these policies may help to identify issues or gaps existing between policy and practice, and if so, in what ways and with what implications.

Further research may also benefit inpatient service development by examining clinician perspectives regarding effective strategies and conceptual frameworks that support the development of a constructive therapeutic alliance between patients and staff and help to cultivate a recovery-orientated mentality in patients. Finally, I propose that further research focusing on patient perspectives explores how models of gender and sexuality impact the inpatient context, considering of how third and fourth wave feminist discourses may generate new ways of thinking about the meanings of eating disorder issues within a 21st century context.

Final Reflections

These research findings bring to life many of the issues identified within the literature review pertaining to the continuation of psychiatry's medical model of treatment. Patients' incisive and impassioned critique of 'feeding clinics' indicate that the legacy of earlier treatment practices and attitudes during the 19th and 20th Century seem to have persevered into the 21st Century within mainstream psychiatric clinics despite the considerable cultural shifts that have taken place regarding societal attitudes and the legal rights of mental health patients. Subsequently, the polarisation of ideology and discourse between mainstream and alternative approaches to research and practice identified in the literature review appear to have re-emerged within the findings of this study to reproduce an ongoing tension existing between the disciplines of psychiatry, psychology and psychotherapy. The dichotomous nature of this debate has arisen in this study in terms of negotiation between the medical model versus person-orientated, standardised versus individualised, outcome versus process, actuarial versus relational, status-quo versus socially critical, quantitative versus qualitative and patriarchal versus feminist. This presents a plethora of dualisms through which mental-health research and practice continue to confront and negotiate their differences. Conclusively, I hope that this study contributes to the integration and collaboration of these disciplines rather than to deepen their divisions. This may depend on the receptivity by which new knowledges arising from service-user research such as this are received and incorporated into current treatment practices.

Appendices

Appendix 1. The Context in which Anorexia Nervosa was ‘Discovered’

The cultural proliferation of medical sciences pursuing a ‘rational method’ superseded religious discourses of power and became regarded as the rightful domain for understanding and treating psychological phenomena (Hepworth, 1999). Nevertheless, religious and medical systems of knowledge remained interrelated with regard to cultural formulations of morality, whereby society’s role in maintaining ‘moral control’ and administering ‘moral treatment’ became a central concern of the medical profession, signifying both an agenda and an instrument that could be employed by physicians in the emerging arena of ‘mental illness’ (Hepworth, 1999).

Sexuality and gender also featured as prominent targets of medical discipline (Foucault, 1965, 1977). As the Other of rational ‘man’, ideological representations of femininity constructed women as ‘irrational’ and ‘emotional’, ‘unstable’ and ‘deviant’ (Ehrenreich and English, 1979; Ussher, 1991) such that “‘women’ and ‘madness’ came to share the same territory, positioned in relation to a fundamentally male norm” (Martin, 1987:42). These conceptions were cohered and consolidated in the notion of hysteria, which was regarded as “a psychological effect of moral fault” (Hepworth, 1999:37), later expanded in social constructions of ‘the nervous woman’ (Showalter, 1985).

Appendix 2. The Challenge to Psychiatry and Evolution of Psychiatric Practice

Cultural trends from the mid 20th Century forward reflected, in some circles, a growing disenchantment with psychiatry in both Europe and America (Hepworth, 1999). Alongside uprisings during the 1960s against various forms of racial, sexual and political injustice, the anti-psychiatry movement (Cooper, 1967) posed a radical challenge to psychiatry by examining the institution in terms of the political ideology it represented and its means of reproduction.

Leading proponents of the anti-psychiatry movement constructed psychiatry as an oppressive form of social control legitimated through imposing standards of normalcy. These figures re-conceptualised mental illness as an expression of existence (Laing, 1960) or human need (Basaglia, 1964) and argued that psychological disturbance was intrinsically related to the social condition of a person's life, proclaiming that the notion of 'underlying disease causation' was neither capable of being proven nor desirable in terms of developing effective treatments (Szasz, 1974).

Meanwhile, Goffman's (1968) ethnographic analysis of psychiatric institutions exposed a series of dehumanising and humiliating practices that depersonalised patients and constructed their 'non-identities'. Laing and Esterson (1964) proposed that effective treatments would be better facilitated through enabling sufferers to engage in a passage of self-discovery. These criticisms appear to have been digested to some extent within the psychiatric field over the past few decades: concerns about harmful effects of institutionalisation are to found in mainstream literature (Gowers, Weetman, Shore, Hossain, Elvins, 2000), whilst practices such as enforced use of enteral feeding through nasogastric tubes are now viewed as controversial and recognised to be potentially psychologically damaging to the patient as well as destructive to the therapeutic alliance (Richards, 2003). Meanwhile, electroconvulsive therapy and psychosurgery have become marginalised as

treatments and compulsory commitments have come under close judicial scrutiny, to be used only as a last resort (Richards, 2003).

Appendix 3. Socio-Political Constructions of Anorexia Nervosa

In light of a diversification of theory, discourse and methodology, a multiplicity of competing constructions of AN have emerged with the objective to expand its location beyond a pathological illness. Socio-political analyses appear to provide the most successful account of anorectics outside a pathological framework offering explanations for why anorexia and bulimia are most prevalent amongst white, educated, middle-class females within Western consumerist society (Clarke, n.d). These analyses examine AN as a manifestation of women's control over their bodies in relation to their lack of power in other areas of life (Lawrence, 1979) and reflect on how the acquisition of thinness is "an obviously culturally-sanctioned enterprise for women" (Gremillion, 1992:57).

Malson (1998) for instance considers women's need to control (and ultimately eradicate) the (female) body in view of the persisting discourse of Cartesian dualism within Western culture. Turner (1992) and Orbach (1993) present 'Anorexia' as a metaphor for, and a manifestation of, contemporary socio-cultural concerns and dilemmas, expressing a cultural conflict between mass consumption and normative thinness (Turner, Hamilton, Jacobs, Angood, Dwyer, 1997; Polivy & Herman, 1987), between the indulging 'consumer-self' and the controlled, abstinent, 'producer-self' demanded by late-capitalism (Brumberg, 1988; Bordo, 1990; Malson & Ussher, 1996a; Malson, 1998).

These studies reconstitute AN as a coping mechanism, a means of achieving a positively construed identity, as a form of self-punishment (Malson, 1998:143) or as a rebellion against 'femininity', conceiving the anorexic body as a *parody* of fashionable thinness (Verbin, n.d; Grey, 2011). This latter reading appears to be particularly pertinent among the rise of third wave of feminists in the late 1990s, who examine how bodies have become the canvasses upon which struggles paint themselves (Richards, 1998).

The phenomena of AN has thus been reconsidered as an object of social construction (Hepworth, 1999), as a phenomena reproduced within psychiatric services (Gremillion, 2003) and analysed in relation to ideological and discursive influences that regulate women's experiences of gender, subjectivity and embodiment (Hsu 1989; Malson and Ussher, 1996).

Appendix 4. A Psychiatric Construction of AN

Eating disorders are thus almost invariably conceptualised within medical or quasi-medical frameworks as 'real' individualised clinical entities (see however Hepworth, 1999; Malson, 1998; Malson & Ussher, 1996). This marginalises the examination of discursive productions of 'eating disorders' (Malson et al., 2004) and precludes exploration of the meanings to be found both within people's experiences of 'eating disorders' (see however Bordo, 1992, 1993; Hepworth, 1999; Malson, 1998, 2000a) and its treatment (see however, Eivors Button, Warner, Turner, 2003; Gremillion, 1992, 2002). The silence about gender, power and politics latent within these (quasi-)medical constructions of AN have been criticised in serving to "normalise the gender inequalities" in family and society which, Malson asserts, "must surely have some bearing on the distress that so many girls and women experience in relation to eating, embodiment and identity" (Malson, 1998:89).

Appendix 5. Diagnostic Criteria for Anorexia Nervosa

DSM-5: Feeding and Eating Disorders

Anorexia Nervosa: 307.1 (F50.01 or F50.02)

Diagnostic Criteria:

A. Restriction of energy intake relative to requirements leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.

B. Intense fear of gaining weight or becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Coding Note: The ICD-9-CM code for anorexia nervosa is **307.1**, which is assigned regardless of the subtype. The ICD-10-CM code depends on the subtype (see below).

Specify whether:

(F50.01) **Restricting type:** During the last 3 months, the individual has not engaged in recurrent episodes of binge eating or purging behaviour (i.e., self-induced vomiting or the

misuse of laxatives, diuretics, or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and /or excessive exercise.

(F50.02) Binge-eating/purging type: During the last 3 months, the individual has engaged in recurrent episodes of binge eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Specify if:

In partial remission: After full criteria for anorexia nervosa were previously met, Criterion A has not been met for a sustained period, but either Criterion B or C is still met. In full remission: After full criteria for anorexia nervosa were previously met, none of the criteria have been met for a sustained period of time.

Specify current severity:

The minimum level of severity is based, for adults, on current body mass index (BMI) (see below) or for children and adolescents, on BMI percentile. The ranges below are derived from World Health Organization categories for thinness in adults; for children and adolescents, corresponding BMI percentiles should be used. The level of severity may be increased to reflect clinical symptoms, the degree of functional disability, and the need for supervision. m2 Mild: BMI > 17 kg/ m2 Moderate: BMI 16-16.99 kg/ m2 Severe: BMI 15-15.99 kg/ m2 Extreme: BMI < 15 kg/" (Grilo 2002:178)

Appendix 6. Cross-cultural studies finding AN as an ‘ego-syntonic’ condition.

Cross-cultural studies reconfirming the ‘ego-syntonic’ nature of the AN reproduces a familiar pathological portrait of the condition. Laseque’s (1873) original articulation of the positive valence of starvation as the most defining feature of the disorder, in which he states that “the whole disease is summed up in this intellectual perversion” (p.495), persists in current clinical descriptions. Orimoto and Vitousek (1992), for instance, emphasise the patient’s positive attitude toward weight loss as *the* essential feature that maintains the anorexic attitude, referring to the “sense of pleasure, accomplishment, and moral virtue anorexics derive from their pursuit of thinness” (p.88).

Appendix 7. Constructivism and Constructionism

Constructivism and social constructionism are closely related terms reflecting similar ontological and epistemological positions. Both contest the positivist idea that the world is objectively knowable, proposing that 'reality' is multiple and constructed rather than singular and objective. Differentially however, constructivism emphasises individuals' biological and cognitive processes in the construction of reality. Constructivists therefore tend to focus on what's happening within the minds or brains of individuals, describing psychological processes and structures at the individual level, leading to an emphasis on phenomenology (Sommers-Flanagan & Sommers-Flanagan, 2012). Social constructionism on the other hand, places knowledge in the domain of social interchange, focusing on what's happening between people as they join together to create realities (Sommers-Flanagan & Sommers-Flanagan, 2012). Social constructionists therefore proposed that knowledge and reality are constructed through discourse and social interaction.

In this study I de-emphasise distinctions between constructivist and social constructionist perspectives since my research enquiry targets both individual and social directions of construction. Reflecting a constructivist perspective, I seek to examine both how individuals' behave and respond under specific conditions to identify how they change according to the social context of inpatient treatment. Corresponding to a social constructionist perspective, I seek to understand how specific contextual conditions of inpatient treatment shape the experiences and identities of the patients within its care. I may therefore use both terms to describe the psycho-social processes I see occurring in the data.

This study's relational epistemology also argues that the interdependence of the social and individual domains of reality and knowledge production often renders the constructivist and constructionist paradigms inseparable, a perspective which Hruby (2001) refers to as macro-constructivism. I shall align myself with both positions however, as Charmaz has

done: Charmaz both refers to her method as constructivist (2000, 2006) and discusses her affiliation with social constructionism (2008), explaining that constructivist grounded theory (Bryant, 2002; Charmaz, 2000, 2002, 2005, 2006; Clarke, 2003, 2005, 2006) has fundamental epistemological roots in sociological social constructionism.

Appendix 8. Recruitment Email



Email to Clinical Staff at ED services:

Dear

I am undertaking a doctoral study exploring ex-patients experience of in-patient treatment and would hugely appreciate your help in the recruitment of participants.

The proposal and ethical procedure have been accepted.

If you are willing to facilitate my project, I would like to permit me to disseminate the recruitment poster (as attached) within the waiting room of your out-patient service.

Below is a short summary of the Project. If you would like further documentation regarding the project do not hesitate to contact me.

Title of Research Project:

The patient's perspective of in-patient treatment for Anorexia Nervosa: An exploration using constructionist grounded theory.

Brief Description of Research Project:

The central aim of this study is to gain insight into patients' experiences of in-patient treatment in order to consider the impact of current treatment provision on people diagnosed with AN. This study aims to utilise the information gathered from ex-patients accounts to contribute to the theoretical development of Anorexia and its treatment. The interview will take roughly an hour in a private location mutually agreed between participant and interviewer. The interview will be audio recorded for the purpose of transcription.

I look forward to hearing from you,

Many thanks,

Roselle Birkbeck

Appendix 9. Recruitment Poster



Have you experienced in-patient treatment for Anorexia Nervosa?

If so, would you like to have your voice heard about what it was like for you?

I am undertaking a doctoral study to explore your experience of in-patient treatment in order to increase the power of the patients' perspective in-patient treatment provision.

I will be carrying out a face-to-face interview to understand your perspective about your experience of treatment.

If you are interested in participating please contact me.

**My name is Roselle Birkbeck.
You can call me on 07881906452
or email me on birkbecr@roehampton.ac.uk**

Appendix 10. Information sheet for Participants



Study Title: The patient's perspective of in-patient treatment for Anorexia Nervosa: An exploration using constructionist grounded theory.

Thank you for contacting me to express an interest in this study. This information sheet tells you about the study to help you decide if you would like to take part. Participation is voluntary and confidential. If you would like to know more information than is provided below, please feel free to ask any questions.

My Contact Details:

Name	Roselle Birkbeck
Department	Department of Psychology
University address	Whitelands College, Holybourne Avenue, London
Postcode	SW15 4JD
Email	birkbecr@roehampton.ac.uk
Telephone	07881 906452

What is the purpose of this study?

The central aim of this study is to gain insight into patients' experiences of in-patient treatment. This study will explore the impact of current treatment provision on people diagnosed with an eating disorder.

The core purpose of this study is to develop greater understanding about the impact that inpatient treatment practice for eating disorders has on its patients. This study perceives that the patients perspectives constitutes a vitally important voice to inform how treatment is designed and delivered. This study aims to represent the voice of patients experience to understand how treatment practices impact upon the people it is designed to help and to inform practitioners about the quality and impact of treatment on their patients.

I am undertaking this study as part of a Doctoral thesis, under the department of Counselling Psychology at Roehampton University. The study will interview between 8 and 20 individuals, with the possibility of follow-up interviews, between the period December 2014 to July 2015. The thesis will be completed between October 2015 and September 2016.

Who can take part?

This study will include participants of any gender, over the age of 18, who have undergone in-patient treatment for an eating disorder within the last 4 years. Participants must have engaged in in-patient treatment for a minimum of 1 month. Diversity of experience and perspective is welcome. A willingness to think about and share your various responses to treatment will be invited.

What will participation involve?

If you decide you would like to take part, I would ask you a few questions by phone or email to check that you fulfil the inclusion/exclusion criteria.

The interview will take roughly 90 minutes in a private location mutually agreed between participant and interviewer. The interview will be audio recorded for the purpose of transcription. The information that you share will only be used for this research study.

Are there any potential disadvantages to taking part?

I hope that you will enjoy participating in the study and find it useful to spend this time reflecting on your experiences of inpatient treatment. This study offers a unique opportunity to have your personal perspectives about treatment reflected within developing theory and knowledge about the appropriateness and effectiveness of treatment.

However, it is also possible that the interview will bring to mind upsetting feelings or disturbing memories. The interviewer, a trainee Counselling Psychologist, has your interest and wellbeing at the forefront of their concerns and will be sensitive to the material you bring, clear in the position that there is no need to share material that you don't comfortable feel with, and protective of your sense of security during the process of interview. You will be free to stop the interview at any time, or to decline answering any question that touches on areas you feel are too sensitive. You do not have to give a reason. At the end of the interview I will provide information about where you could get more information and support.

Will my data be anonymous?

Interview transcripts and questionnaires will be stored anonymously in password protected files and a locked filing cabinet. Note: At no stage following the interview will your name be associated with the transcript generated from your interview. Your name and contact details will be securely stored separately. Your name will be replaced by a code on stored documents. Your name will be replaced with a pseudonym if directly referenced within the final paper. In accordance with University of Roehampton guidelines, the transcript will be kept for 10 years. Authorised University of Roehampton staff and representatives from professional bodies for the purpose of assessing the quality of the research will read some data.

Are there circumstances where confidentiality would be breached?

The researcher is regulated by the British Psychological Society and is committed to following its Code of Conduct. If you disclose information which causes concern about your safety, or the safety of others, it may be considered necessary to inform an appropriate third party without formal consent.

The researcher would discuss this first with the project supervisor, unless delay would involve significant risk to life or health.

What will happen to the results of this study?

The study will be written up as a thesis to form part of a doctoral portfolio submitted for qualification as a Chartered Psychologist. The findings may also be published in research articles in the future.

You would not be identifiable in any of these publications. You would be informed of any publications and can be sent a summary of the findings on request.

What can I do if there is a problem?

If you are unhappy or concerned about any aspect of taking part in the study, please raise it with the researcher. If you remain unhappy or wish to complain, then you can contact the Director of Studies, overseeing this research, or the Head of Department:

Director of Studies Contact Details:

Name	Moon, Dr Lyndsey
Email:	Lyndsey.moon@roehampton.ac.uk
Telephone:	020 8392 5773
Address:	Room: 3021 Whitelands College, Holybourne Avenue, London

Postcode SW15 4JD

Head of Department Contact Details:

Name Bray, Dr Diane
Email: d.bray@roehampton.ac.uk
Telephone: 020 8392 3627
Address: Room: 2053 Whitelands College, Holybourne Avenue, London
Postcode SW15 4JD

Right to Withdraw

Participants have the right to withdraw at any time without giving a reason. If the participant wishes to withdraw from participation in the study, either in its entirety or a specific section, they can give their ID number provided in the debriefing form at the beginning of the interview to the interviewer. Following January 2015 data may be in an aggregate form within the research analysis and may therefore be unable to exclude. Full transcript can however be destroyed.

Appendix 11: Check List inclusion/exclusion criteria



Title of Research Project:

The patient's perspective of in-patient treatment for Anorexia Nervosa: An exploration using constructionist grounded theory.

Participant Number:

This is to confirm that the participant is:

- Over 18 years old
☐
- Has undergone in-patient treatment for an eating disorder within the last 4 years.
☐
- Has engaged in in-patient treatment for a minimum of 1 month
☐
- Is not currently experiencing suicidal ideation or attempts of suicide.
☐

Appendix 12: Demographic Questionnaire



Title of Research Project:

The patient's perspective of in-patient treatment for Anorexia Nervosa: An exploration using constructionist grounded theory.

Questionnaire

Any questions you don't feel comfortable answering please feel free to disregard. Any concerns or queries you have regarding this questionnaire please feel free to ask.

Participant Number:

Age

Gender

Sexuality

Ethnicity

Nationality

Religion

History of inpatient admissions (including date, location and duration of each admission)

.....

.....

.....

.....

History of engagement with out-patient services (including dates, location and duration of use of out-patient treatment)

.....

.....

.....

.....

Date of self-identified onset of their ED

Date of first diagnosis of AN

Nature of eating disorder/ characteristics (eg. restrictive, binge purge or otherwise identified).

.....

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.....

.....

.....

Personal sense of recovery status.

.....

.....

.....

.....

.....

Appendix 13: Consent Form



PARTICIPANT CONSENT FORM

Title of Research Project:

The patient's perspective of in-patient treatment for an eating disorder: An exploration using constructionist grounded theory.

Brief Description of Research Project:

The central aim of this study is to gain insight into patients' experiences of in-patient treatment in order to consider the impact of current treatment provision on people diagnosed with Anorexia. This study aims to utilise the information gathered from ex-patients accounts to contribute to the theoretical development of Anorexia and its treatment.

The interview will take up to an hour and a half in a private location mutually agreed between participant and interviewer. The interview will be audio recorded for the purpose of transcription. The

researcher may contact the participant following the interview to request a follow-up interview. This will be for the purpose of methodological validity only.

Right to Withdraw

Participants have the right to withdraw at any time without giving a reason. If the participant wishes to withdraw from participation in the study, either in its entirety or a specific section, they can give their ID number provided in the debriefing form at the beginning of the interview to the interviewer. Following January 2015 data may be in an aggregate form within the research analysis and may therefore be unable to exclude. Full transcript can however be destroyed.

Are there circumstances where confidentiality would be breached?

The researcher is regulated by the British Psychological Society and is committed to following its Code of Conduct. If you disclose information which causes concern about your safety, or the safety of others, it may be considered necessary to inform an appropriate third party without formal consent. The researcher would discuss this first with the project supervisor, unless delay would involve significant risk to life or health.

Investigator Contact Details:

Name	Roselle Birkbeck
Department	Department of Psychology
University address	Whitelands College, Holybourne Avenue, London
Postcode	SW15 4JD
Email	birkbecr@roehampton.ac.uk
Telephone	07881 906452

Participant Consent Statement:

I agree to take part in this research, and am aware that I am free to withdraw at any point. I understand that the information I provide will be treated in confidence by the investigator and that my identity will be protected in the publication of any findings.

Name

Signature

Date

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However, if you would like to contact an independent party please contact the Head of Department or the Director of Studies.)

Director of Studies Contact Details:

Name Moon, Dr Lyndsey

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Head of Department Contact Details:

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Appendix 14. Demographic Graph

Name	Age	Gender	Sexuality	Ethnicity	Nationality	Religion	No. of Inpatient Admissions	Total Duration of Inpatient Admissions	Types of Clinic	Age of diagnosis	Nature of Eating Disorder and Comorbidities	Self Identified Onset of ED	Contact with Outpatient services	Estimated weight
P1 Anna	19	F	Heterosexual	White/ European	British	Non-practicing Christian	2	4 mths	ED specialist Private Residential/Inpatient	17	Restrictive/ self harm	17	2.5 yrs	Anorexic Range - Underweight
P2 Becky	28	F	Heterosexual	White/ Chinese	British/ Chinese	Unspecified	1	6 mths	ED Specialist NHS Inpatient	13	Binge/Purge/Restrictive	Prior to 12 yrs old	15 yrs	Critical - Severly Underweight
P3 Cathy	32	F	Heterosexual	White/ Turkish	British	None	10	4 yrs	ED Specialist NHS Inpatient & Private Inpatient services	23	Restrictive only	15	9 yrs	Critical - Severly Underweight
P4 Danielle	29	F	Bisexual	White/ European	British	Unspecified	5	18 mths	Addiction specialist private clinics	Mid 20's	Binge/Purge/Restrictive /compulsive/self harm/alcoholism/drug addiction	Unspecified	Unspecified	Normal/ Underweight
P5 Emily	27	F	Heterosexual	White/ European	British	Unspecified	3	1 year	ED Specialist NHS & Private Addiction Residential	18/19	Binge/Purge/Restrictive /compulsive/self harm/alcoholism/drug addiction	Unspecified	15 yrs	Normal/ Underweight
P6 Fiona	18	F	Heterosexual	White	British	Agnostic	10	3.5 yrs	General Psychiatric/ Specialist ED child Adolescent unit	14	Restrictive only/self harm	11 or 12	12 yrs	Severely underweight
P7 Gina	43	F	Heterosexual	White/ European	British	Unspecified	10 +	4+ yrs	unit/ Specialist ED NHS unit	21	Restrictive only	21	Unspecified	Critical - Severly underweight
P8 Helen	22	F	Bisexual	White/ European	British	No Religion	2	9 mths	Specialist Ed NHS and Private/Local funded Specialist ED Clinic	17	Binge/Purge/Restrictive	13	Ongoing	Anorexic Range - Underweight
P9 Iris	20	F	Heterosexual	White/ European	British	Unspecified	4	2.2 yrs	General Psychiatric Unit Child / Specialist ED child/Adolescent Unit	13/14	Restrictive only	10	Unspecified	Critical - Severly Underweight
P10 J	56	F	Heterosexual	White/ European	British	Unspecified	4 (excluding hospital admissions)	Unspecified.	General Psychiatric adult unit/ Specialist ED NHS unit/ ED Specialist local authority/private inpatient	18/19	Restrictive only	10	Unspecified	Critical - Severly Underweight
P11 Karen	23	F	Bisexual	White/ European	British	Unspecified	1 (plus 1 hospital admission)	6 mths	ED specialist Private Residential/Inpatient	22	Restrictive only	22	Unspecified	Normal / Underweight

Appendix 15. Debriefing Sheet & Follow up Support for Participants



Title of Research Project:

The patient's perspective of in-patient treatment for Anorexia Nervosa: An exploration using constructionist grounded theory.

Brief Description of Research Project:

The central aim of this study is to gain insight into patients' experiences of in-patient treatment to consider the impact of current treatment provision on people diagnosed with Anorexia. This study aims to utilise the information gathered from ex-patients accounts to contribute to the theoretical development of Anorexia and its treatment.

The interview took up to an hour and a half in a private location mutually agreed between participant and interviewer. The interview was audio recorded for the purpose of transcription. The researcher may contact the participant following the interview to request a follow-up interview. This would be for the purpose of methodological validity only.

Right to Withdraw

Participants have the right to withdraw at any time without giving a reason. If the participant wishes to withdraw from participation in the study, either in its entirety or a specific section, they can give their ID number provided in the debriefing form at the beginning of the interview to the interviewer. Following January 2015 data may be in an aggregate form within the research analysis and may therefore be unable to exclude. Full transcript can however be destroyed.

Are there circumstances where confidentiality would be breached?

The researcher is regulated by the British Psychological Society and is committed to following its Code of Conduct. If you disclose information which causes concern about your safety, or the safety of others, it may be considered necessary to inform an appropriate third party without formal consent. The researcher would discuss this first with the project supervisor, unless delay would involve significant risk to life or health.

Support Services

For further support following the interview, below are some services specialising in eating disorders:

- BEAT – Information and Support for Eating Disorders <http://www.b-eat.co.uk/get-help/get-support/helpline/>

Helpline: Beat's Helplines are open from Monday to Friday 1:30pm to 4:30pm and Monday and Wednesday evenings 5.30pm to 8.30pm.

The Beat Adult Helpline is open to anyone over 18 who needs support and information relating to an eating disorder, including sufferers, carers and professionals.

Helpline: 0845 634 1414

Email: help@b-eat.co.uk

- Workshop Self Help and Support Group in and around London. Taken from BEAT website (<http://helpfinder.b-eat.co.uk/listings.asp>)

- FREED, 39 Park Street, Worksop, S80 1HW

Type: Beat Self Help & Support Groups

- London N3 Self Help and Support Group for Sufferers

Golders Green,

Tel: 07962 392908

Email: flemonsky@sky.com

Type: Beat Self Help & Support Groups

- Woking Self Help and Support Group for Sufferers

Cornerhouse, 2 Courtenay Rd, Woking, GU21 5HQ

Tel: 01483 757461

Email: info@beatwoking.org.uk

Type: Beat Self Help & Support Groups

- Maidstone Self Help and Support Group for Sufferers and Carers

Priority House, Maidstone Hospital, Hermitage Lane, Maidstone, ME16 9QQ

Type: Beat Self Help & Support Groups

- Sussex ED Carers' Self Help & Support Group

Ashenground Community Centre, Southdown Close, Haywards Heath, RH16 4JR

Tel: 0300 028 8888

Email: info@carerssupport.org.uk

Type: Beat Self Help & Support Groups
- Norwich Eating Disorders Group

The Charing Cross Centre, 17-19 St. John Maddermarket, Norwich, NR2 1DN

Tel: 01603 753334 or 07535 418424

Email: norfolkgroups@b-eat.co.uk

Type: Beat Self Help & Support Groups
- Chesterfield Image Self Help Group

NEDCASH, The Annexe, Holywell Health Centre, Holywell Street, Chesterfield, S41 7SH

Type: Beat Self Help & Support Groups
- Edgbaston Self Help and Support Group for People Experiencing Eating Issues

Woodbourne Priory Hospital, Woodbourne Road, Edgbaston, B17 8BY

Tel: 0121 434 4343

Type: Beat Self Help & Support Groups
- LINK:ED Lincolnshire Eating Disorder Self Help Group

Dean's Building, Lincoln College (ask for Link-Ed Group at Reception), Monks Road, Lincoln, LN2 5HQ

Tel: 01476 584005

Type: Beat Self Help & Support Groups

- Cirencester Self Help and Support Group for Sufferers and Carers

St Peters Court (lounge), St Peters Road, Cirencester, GL7 1RG

Type: Beat Self Help & Support Groups

- Anorexics and Bulimics Anonymous (ABA)

Groups run throughout locations in London. See: <http://aba12steps.org>

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator or you can contact the Director of Studies. However, if you would like to contact an independent party please contact the Head of Department.

Investigator Contact Details:

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Head of Department Contact Details:

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Postcode SW15 4JD

Appendix 16: Interview Question Outline



Title of Research Project: The patient's perspective of in-patient treatment for Anorexia Nervosa: An exploration using constructionist grounded theory.

Interview schedule

All interviews will begin with the questions:

“What made you decide to participate in this study?”

“Would you like to tell me about your experience of in-patient treatment?”

Prompting questions may be used if particular areas of interest are not reflected on by the participants.

These may include questions such as:

How did it feel to be in inpatient care? / How did you feel when you were an in-patient?

Were there any particular aspects/elements of your experience that stood out, you responded/reacted to strongly?

What elements of treatment have you found helpful/constructive, unhelpful/destructive?

To what extent did you feel willing to engage in treatment?

How did you experience your relationship with staff?

What impact, if any, did inpatient treatment have on your relationship with your eating disorder?

Are there other ways inpatient treatment affected you?

Has your feeling about inpatient treatment changed since you left?

If so, in what way

Has your experience within inpatient treatment had a lasting impact. If so how?

Appendix 17. Theoretical Saturation.

When using GT methods, analysis is considered completed when ‘theoretical saturation’ occurs. The process of reaching towards theoretical saturation involves looking for data that expands and identifies more properties of a theoretical category. Saturation therefore describes the point in which new data no longer contributes new theoretical insights towards category development (Charmez, 2006). At this point, the categories are believed to have sufficient strength to support the grounded theory (Glaser, 1998).

Despite my uncertainty that saturation can ever be definitively achieved owing to the unpredictable variation of human experience and response, the astounding resonance, symmetry and unity of messages communicated through the 11 participants accounts within this study lead me to feel confident that most categories had reached saturation, since subsequent interviews increasingly produced data that reinforced the findings identified in previous interviews, rather than significantly elaborating or expanding them. However, with the capacity for a larger project, I could potentially have developed further questions that would have enabled greater theoretical insights into the social processes occurring within these contexts.

Appendix 18. Example of Initial/Line by Line/Open coding

Participant 1: Anna

<p><i>Can I ask you what kind of relationships you had with staff?</i></p> <p>We had different relationships with different staff. The nurses were, on the whole, deeply loving. You know you could go and have a fag with them and talk about things, talk about how you were finding the team difficult.... there was always a nurse there, if you didn't sleep, there was always a nurse awake there, you could go in and sit and chat with them. And they would give you a hug if you wanted a hug. Sometimes I think about going back and I say I wanna go back and see my mummas . I really, and they had a wonderful sense of humor...theres that humor that goes with recovery that is very important. One of them used to go 'I watch u like a hawk, I give you a hiding, and then I give you a</p>	<p>Identifying different relationships.</p> <p>Generalising experience of relationship with staff as 'Deeply Loving'</p> <p>Developing trust</p> <p>–through Reflective dialogue and honesty and informal interactions</p> <p>'Always' –suggesting reliability of staff presence</p> <p>Supporting through physical affection.</p> <p>Becoming attached- wanting to return.</p> <p>'My mummas' – symbolic presence of nurses as safe, familial carers.</p> <p>Emphasising value of humour and laughter in recovery.</p>
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<p>hug'</p> <p>(Laughter) And she was about this big!</p> <p>And they would talk to us, and play games, and sit with us and chat with you and they had a very ballsy sense of humour, which was amazing. Umm and.... They'd laugh with you, they'd ask about you, they'd have a conversation with you, they were interested in you, as well, and it was very loving. ...they were not, and they would be harsh if they felt you had acted wrongly, and they would not rescue you, in the therapeutic sense, rescue you from taking responsibility, but they were absolutely there. You know, some more than others, some you would get on well with, some would piss you off. Umm</p> <p><i>They were constant?</i></p> <p>They were constant. Absolutely constant. And ... And that sort of level of intimacy but also boundary, that was very much a solid force. That was</p>	<p>Maternal containing. Controlling with Love.</p> <p>Informality and presence - creating intimacy and genuine relationship.</p> <p>Experiencing naturalness of care.</p> <p>Being treated as interesting.</p> <p>Summarising open, honest and curious dialogue as 'loving' care.</p> <p>'they were absolutely there' – feeling connected, feeling contained.</p> <p>Emphasising Value of staff's emotional availability</p> <p>Perceiving relationship with staff as varied.</p>
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<p>so comforting.</p> <p>The therapists ..they would laugh with you too. but they were also there to do the serious stuff. The deep work, the no qualms about it, and quite often you're, it certainly felt like, it's a lot of tough love with the therapists... and for me that's exactly what I needed. I didn't need , I needed to be you know, I needed someone who was solid</p> <p><i>Someone you could rely on?</i></p> <p>Someone I knew where I stood with.</p> <p>Someone I felt, yeah, exactly, someone who I could rely on, who was there, but wasn't afraid to.. someone I could test and they would still be ok. And I wouldn't have to change the way I was around them. And it wasn't that inconsistency. I wasn't always having to work out, they were open, they were blunt, umm that was actually quite a good model for me. And someone I felt I could trust. .. And someone who was .</p>	<p>'tough love' – “someone who was solid” – “comforting” –.</p> <p>Feeling comforted, safe from receiving intimacy/warmth alongside boundary</p> <p>Identifying relational needs.</p> <p>Consistency – “Someone I knew where I stood with.”</p> <p>Reliability- “someone who I could rely</p>
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<p>there was very much a sense at X that they were there for you, they were not there for your eating disorder. ...they were there to extract you, and sometimes you would have to dig very deep to extract someone from that. But they were there for you. And sometimes you're not there for yourself, but they were there for you that was sometimes very lost or very deep or very unsure, and so that solidity. Firmness, to the point sometimes of being harsh, sometimes being strict, was actually what was needed. Because you had to be very rigorous.</p> <p><i>How did they conceptualise the eating disorder?</i></p> <p>Well they always talked about it as 2 separate people. There's you and there's your E-D. Um and they always talked about your E-D. Your E-D. And that is</p>	<p>on"</p> <p>Testing staff – finding consistency.</p> <p>Staff attitude/communication as a model for patient's own self-development</p> <p>"they were there for you, they were not there for your eating disorder"</p> <p>Learning to trust – discovering the other can be dependable, consistent.</p> <p>digging to extract the person from the illness.</p> <p>Staff showing commitment to the patient as a person.</p> <p>Trusting staff before trusting oneself.</p> <p>Rooting for the non-ed part of patient when it's not visible.</p> <p>Valuing firm boundaries. Feeling held.</p>
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<p>helpful because it means you are not caught up in it. in a way. You are not caught up in a blame or a scheme, and it is something that can be labelled as a malevolent presence.</p> <p>Did they demonise the E-D?</p> <p>I wouldn't say demonise, but they. They wouldn't say 'you're bad', they would say ' your ED is very strong at the moment'. And it would be 'you're struggling', if you're acting out, 'you're struggling' and that gave a sense that, unlike NHS, that you were not a bad person. We had to repeat every morning , I'm not a bad person, I have an eating disorder, before we start a meditation. And that was something again, I could believe that, I could not believe, that I could not be a bad person. And it was something that took me a long time to loose. It didn't make me, integrally, bad, if I was struggling with an eating disorder. And that doesn't excuse the</p>	<p>Needing another to be stronger than the illness</p> <p>Valuing staff rigour.</p> <p>Treatment framework – differentiating the illness and the person.</p> <p>Labeling the E-D.</p> <p>Locating negative thoughts as the E-D.</p> <p>Addressing the person –</p> <p>Conceptualising the E-D as a separate entity.</p> <p>Differentiating 2 separate aspects of character.</p> <p>Learning (through relationship) to experience self acceptable despite being afflicted.</p> <p>Comparing to other treatment experiences in which interactions</p>
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<p>eating disorder, but it was about creating a separation.... anything that was malicious, anything that was unhelpful or unsupportive to you could be labelled as part of your ED. Whether that was, ‘well of course they did that, they don’t really like you’ or something like that, it didn’t have to be specifically around food. That critical destructive mind. In the same way X would call it ‘the addict’. Umm that was. That was your ‘ED’.</p> <p>But we were also asked to identify the purpose of our ED. What did it express? If it could shout something. mine was probably pejoratively anger. But it did have a purpose. And we had to honour that purpose. And we had to accept it. Before you let it go you have to say, look, you’ve served your purpose, you did have a purpose, I’m .. in my case, you aren’t a sort of indulgence vanity thing, which is in my head what I always told, again in a destructive way. And that again meant that you could separate</p>	<p>generate sense of self as intrinsically bad.</p> <p>Releasing identity of self as ‘bad’ – a challenging process.</p> <p>Ritualising – separation between illness and person.</p> <p>ingraining separate sense of self through meditation.</p> <p>Associating/labelling unhelpful & unsupportive mental processes with/as the ED</p> <p>Broadening conceptualisation of ED as beyond food.</p> <p>Identifying the ED as the ‘critical destructive mind’</p> <p>Examining and Engaging with the purpose of the ED.</p>
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<p>yourself out from it. You didn't have to identify as one with it. Which was helpful.</p>	<p>Valuing, honouring its purpose before letting go.</p> <p>Reconstructing ones perspective on what the ED reflects about self.</p> <p>Challenging view of ED as a 'vanity thing'.</p> <p>Separating , letting go of ED identity</p> <p>Being given permission to relinquish the ED identity.</p>
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Appendix 19: Example of Focused Codes

Participant 2: Becky. Developing Focused Codes from in vivo quotes and initial codes

Failing to feel trust	<ul style="list-style-type: none"> Analysing professional motive/proposing senior staff agenda about ego and research status. ‘I felt I was being lied to’ feeling patronised I felt that because I didn’t fit the criteria...they didn’t really know what to do with me’ I had a strong sense of mistrust of any sort of healthcare professional working in eating disorders...didn’t trust any of them’ I felt beyond help, I didn’t think anyone could help me.
Criticising a lack of choice in treatment	<ul style="list-style-type: none"> ‘you have no choice...regardless of what might be useful to [the patient] or not’ feeling forced into receiving the clinicians research agenda– Its different if you’re consenting...to be in a study, but when its actually your treatment...then it doesn’t feel very good’

	<ul style="list-style-type: none"> • ‘not being allowed to make decisions’
Criticising treatment’s lack of understanding	<ul style="list-style-type: none"> • Quite quickly I felt they did not know what the hell they were doing • ‘I felt, clearly you don’t understand where this is all coming from’ • ‘a lot of them didn’t know what to say or do, and they were the ones working there permanently • “nobody knew what they were doing, even the more senior staff” • I did feel that they thought it was a choice • The messages from the staff were ‘you have to want to get better, you know , make that choice’ • I think the staff have no idea quite how unpleasant and distressing and disempowering it is being there.
Feeling unsupported	<ul style="list-style-type: none"> • During meal’s there was no support available • There was no one around to talk to • Going round and round in circles • I felt very fobbed off • It felt like nobody was listening to you.
Being objectified and	<ul style="list-style-type: none"> • Feeling patronised – treated as if

dehumanised as ‘an anorexic’	<p>‘ignorant’</p> <ul style="list-style-type: none"> • ‘they way they spoke to you, they didn’t take you seriously: ‘Oh that’s just the eating disorder talking, was the standard response • ‘it felt as though, they thought, get your BMI up to a certain level and it will all be fine. Basically all of these thoughts and feelings are a consequence of having a low BMI’ • “they don’t even treat you like a human being, let alone somebody who is capable of intelligent or rational thought.”
Contesting a medical approach	<ul style="list-style-type: none"> • No matter how much bingeing and purging you are engaging with...the problem became my weight and not the behaviours. • Diagnosis as ‘arbitrary’ • They can treat the weight but there’s no treatment of the underlying problem • The approach was basically treat the weight problem. And that’s about it • Focusing on symptoms, and not dealing with the psychological side.
Conceiving ED as a cognitive and	<ul style="list-style-type: none"> • ‘The behaviours ...are a symptom of the

emotional problem	<p>problem'</p> <ul style="list-style-type: none"> • The problem – 'negative thoughts and extreme dislike of myself' • 'The behaviours are a way of trying to deal with these thoughts and feelings.' • 'Feeling completely unacceptable'
Viewing staff as disempowered deliverers of the system	<ul style="list-style-type: none"> • 'the psychologist ...didn't really have any option...it was clear she was having to follow this script' • 'Everybody was so scared of deviating from whatever the protocol was' • in some ways their hand's are tied, there's not much they can do as an individual, they can't really go against the system'
Withdrawing from relationship	<ul style="list-style-type: none"> • 'I just gave up on being open' • giving up speaking to staff
Giving up hope	<ul style="list-style-type: none"> • I just felt there was no point, they clearly didn't understand • I cant get rid of it, the professionals cant help, so the only way to move forward is to, I dunno, exist with it' I didn't really want that, but I couldn't' really see any alternative' • I just became so convinced that nobody could help'

	<ul style="list-style-type: none"> • It felt so engrained and powerful’ • Dismissing treatment as pointless • Believing in the voice of the ED • I gave up at that point • ‘It was very distressing , because I thought I’m in the national centre nad this is the best hel that they can offer me and it felt really really helpless’ • What’s the point in talking to anyone and saying how I’m thinking and feeling if it doesn’t get listened to.’ • Dismissiong sevices as a ‘waste of time’ • ‘I felt beyond help’
Spiralling out of control	<ul style="list-style-type: none"> • The bulimic behaviours became more and more extreme
Symbolic embodiment:	<ul style="list-style-type: none"> • If my weight goes up ... everything feels wrong, about myself, about my body...I feel dirty in a way..yeah dirty, like something has to be dealt with.
Identifying purpose of ED	<ul style="list-style-type: none"> • The only way I know how to deal with it is to resolve the weight thing or switch off by binging and purging so I don’t think about it.
Feeling unsafe – Context as Chaos	<ul style="list-style-type: none"> • At [X clinic] it felt like complete chaos.

	<p>They couldn't even get the basic level of staffing right</p> <ul style="list-style-type: none"> • Basic day to day stuff , completely disorganised • Staff were 'usually dealing with someone who was throwing stuff or having some kind of tantrum. •
Hoping for safe containment.	<ul style="list-style-type: none"> • 'I almost felt a bit relieved, because I felt....maybe if I'm contained within this place, maybe I won't be able to do the behaviours. • [I] would like to be able to feel safe enough...[to] suspend control, but it requires a lot of trust, feeling safe and believing there could be some benefits there.
Standardising treatment	<ul style="list-style-type: none"> • 'Standard, prescriptive how it works on their terms and that's what you do.' • 'the protocol'
Relational Animosity – feeling blamed in the role of 'patient', self-blame	<ul style="list-style-type: none"> • 'If you don't fit that then you're just being difficult or you're not engaging' • 'no matter how much help we give you its never going to be enough. Which made me feel like I was being difficult, I was

	<p>too demanding, it was all my own fault</p> <p>anyway, I should just shut up and just get on with it.</p> <ul style="list-style-type: none"> • It was my fault that I didn't fit their protocol • I don't like being locked up and restricted and treatment as though I'm a child • Dr X hates all her patients.. she is a danger to patients in that she makes people feel psychologically worse.. the advocate described the behaviour as bullying and unprofessional. • 'At X they don't give a shit...they don't care if you get better, if you don't get better, if you want to kill yourself, if you've got any hope fo the future or if you've got a ob or some kind of career...they don't give a shit, tey just want you off their books' • I did feel that they thought it was a choice • The messages from the staff were 'you have to want to get better, you know , make that choice' •
Feeling disempowered	<ul style="list-style-type: none"> • 'they are in a position of absolute power

	and there's nothing you can do...as a patient you can't go against the system, you have no power whatsoever
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Appendix 20: Focused Coding: Developing Tentative Categories

From Interviews 1, 2, and 3: Anna, Becky, Cathy

Treatment Standardisation

- Uniform approach to treatment
- Prioritising service agenda over patients needs
- Prescriptive/protocol/ No individuality

Experiencing disempowerment

- Excluding patient voice
- Staff as disempowered deliverers of system
- Depressing Environment – cultivating suicidal feelings
- Places of hopelessness – ‘doom and gloom’
- lacking opportunity to take responsibility

Fast-tracking weight-gain

- Rejecting the feeding clinic/ ‘Hell hole’ / sickening
- Criticising Weight gain focus - ‘it’s the food not the feelings’
- lacking psychotherapeutic input
- Entrenching ED behaviours – ED as expression of lack of control
- Developing a weight orientated perspective (embedding Anorexia)
- Degenerating relationship with food

Lack of Understanding about Eating disorders

- Perceiving incompetence
- Feeling Misunderstood
- Clueless staff
- Contesting a medical approach – diagnosis as arbitrary/ not about weight
- problematising weight not behaviours or emotional causes
- Viewing ED as emotional/cognitive problem
- ‘Idiots’ / ‘no idea’ about treating ED
- making ED worse - Embedding Illness

Objectification

- Feeling pathologised
- Feeling undermined
- Feeling dehumanised
- Feeling infantilised
- Feeling insulted
- Feeling like a statistic
- Voice lacking validity
- Fostering self-doubt

A context of combat and animosity

- Feeling forced
- Facing ultimatums
- Feeling ‘done to’
- Fighting against weight objectives

- Relational Animosity – Feeling hated
- Identifying unethical practice – bullying practitioners
- Feeling like a bad patient/bad person
- Feeling Punished
- Experiencing self-blame
- Illness doing anything to survive
- Feeling given up on – needing to be believed in

Developing Distrust/ Lack

- Feeling Unsupported
- Lack of staff availability – meals/talk to
- Feeling fobbed off
- Feeling unseen
- Experiencing lack of empathy
- Feeling Unsafe – Context as Chaos
- Emotional uncontainment
- Managerial disorganisation
- Feeling blamed for ‘being difficult’ / ‘not fitting’
- Receiving negative messages about ‘being too much’
- Feeling uncared for
- Identifying unethical practice – bullying practitioners
- Perceiving incompetence

Compliance and deception

- Hiding struggle/pretending to manage

- Wanting to please/ fear of disappointing others/ ‘maintaining good girl identity’
- Lacking sufficient safety for honesty
- Complying with others demands
- Lacking trust in other/in self
- Illness playing into staff weaknesses
- Scared into conformity

Withdrawing from relationship

- Giving up speaking
- Exacerbating isolation & fear
- Depicting other patients as dangerous
- Fabricating food diary
- Coping alone
- Lacking resources to manage eating
- Lacking safety
- Patient anonymity

Embedding Anorexia

- Exacerbating negative self-beliefs/low self-esteem
- Illness thriving on low social value
- Lacking a voice

Failing at recovery

- Giving up hope
- Becoming a hopeless case/ Feeling beyond help

- lack of staff belief in patient capacity Places of hopelessness – ‘doom and gloom’
- Feeling unacceptable
- Illness having the power
- Accepting living with the illness
- Reinforcing negative sense of self/bad patient
- Fear of failing high expectations

Collaboration /sharing power/ Autonomy

- Staff empowered
- Developing autonomy
- Having a say in treatment
- Having control over treatment goals
- Collaborating in treatment decisions
- Pacing rate of change
- Valuing individually tailored care
- Devolving trust – learning to take responsibility

Differentiating self from illness

- Conceptualising the ED as a separate aspect of character
- Identifying ED as malevolent presence/force of its own
- Separating/distancing the ED self from other aspects of the self
- Real self being ‘hailed out’ by treatment
- Not being vilanised by treatment
- Staff addressing the non-ill self
- 2 minds battling - Struggling to distinguish and negotiate self conflicting positions

Treatment as place for self-development

- Oriented to emotional process
- Claiming a voice
- Full therapeutic programme
- Ethos of Valuing feelings
- Permission to feel and express
- Treatment believe in patient capacity to recover
- Developing psychological conceptual frameworks
- Fostering direction/pride/openness/humility
- Disproving fears/ challenging negative beliefs
- Growing self acceptance
- Understanding the ED
- Multi-modality approach
- Developing self worth through expressing feelings
- Developing sense of permission

Craving Safe containment

- Turning towards the other for help
- Needing to be put in a place
- Craving containment/safety
- Surrendering to treatment care
- Needing 'water-tight' containment

Experiencing institutional and relational containment

- Feeling held
- Experiencing Care
- Genuine staff interest and job value
- Staff availability – emotional and temporal
- Developing sense of belonging
- Patient to patient relationships
- Positive group dynamics
- Experiencing connection
- Valuing humour
- Communication as an integrated system in treatment
- Stepping off the treadmill
- Needing impatient boundaries and containment
- Recognising power of relationship in treatment
- Experiencing Team cohesion
- Feeling exposed
- Moving forwards together
- Valuing consistency
- Protection

Reflecting on necessity of trust

Needing the support of a positive therapeutic alliance

Receiving ‘tough love’ : control with care

- ‘Knowing where you stand’ – consistency
- reliability

- non-punitive control - testing boundaries without being punished
- trusting the other

Re-orientating for Recovery

- developing desire for wellness/living life
- discovering life can be manageable – relational needs met, relinquishing need for food control
- permission to be happy
- Self-monitoring
- Maintaining Vigilance
- Developing self-trust
- Affirming ones needs/wants
- Developing emotional view of self – the reflective self.
- Taking responsibility for self-feeding
- Finding strength from positive identities/capabilities/interests

Appendix 21: Saturating Categories

Integrating Interview 9 (Iris) into Tentative Categories

Standardising treatment	“Feeding Clinics’ reproducing the problem	“Feeding clinics cause rotating door syndrome”.
Objectification of patient through medical gaze	Places that exacerbate/deepen the illness.	<p>I realise I have been a patient 5/6 times now and nowhere has helped me.</p> <p>Every single inpatient treatment I have had so far has made things worse. Has made me relapse with even more of a vengeance, and it has caused me to be in an even worse place in my head</p>
	Fast tracking treatment – through high rate of weight gain	<p>They want you in and out as quick as possible. Where you’ve got to gain this much per week</p> <p>They got you up to a very high number of calories very quickly.</p>
	Medical mismanagement: violating patient body to fulfil treatment objectives.	<p>Weight gain focus at the cost of interest in/relationship with patient</p>
	Pathologising patient issues/needs	<p>Progress as weight gain (sole treatment focus)</p> <p>They didn’t care about the whole re-feeding syndrome which I experienced quite badly</p>
	Conflating the person with the illness.	<p>Dismissing physical allergies as ‘the illness talking’</p> <p>You are all just an illness</p>

Rigid pathological view as Dehumanisation.	Experiencing Pathology status as Identity. Reinforcing negative self-beliefs	Receiving the message that as individuals they are 'too much'
	Dismissing patient dignity within routine procedures	made to strip, weighted, with the people staring at us.
Standardising treatment	Depersonalisation (Systemic Anonymity)	we didn't see our consultant at all, they would just see us as a piece of paper They didn't make any effort to get to know you as a person, you were just a patient.
	Criticising efficacy of high rate of weight gain	I tried to fast track recovery in the past and it messed me up so much.
	Devaluation of individual identities	Oh we can't treat you as individuals because that's too hard. You are all the same.
	Standardisation explained as a method of simplification.	
	Approach to treatment – shaped according to convenience (ease) of management and staff.	
Subjugation	Infantilisation emerging from lack of control/disempowerment.	I just felt like such a child. I felt like I had no control.
	Accounting for relapse as an effect of negative treatment experience.	Its <i>because</i> that place was so horrible that I am where I am and that's caused me to relapse so badly again. But, its as though you can't really explain it. It was so horrible that its affected me so badly.
	Staff Animosity Lack of empathy	They were so horrible to me There was no understanding. No sympathy

	<p>Feeling Hated/ Negative intersubjective mood.</p> <p>Staff erroneous accusation of patient deceptivity.</p> <p>Being accused of deception unjustly</p> <p>Constructing anorexic patient as deceptive.</p> <p>Conceptualising anorexia as a monstrous expression of deviance</p> <p>Feeling persecuted</p> <p>Identifying coercion as cause of failure of treatment services.</p> <p>Reward and Punishment</p> <p>Treatment using Food as means of Punishment</p>	<p>In other places I've been to you get the impression that they hate their job...</p> <p>They are just so unfeeling and so pissed off all the time... There's no support, no humanity</p> <p>Treatment assuming deception of patient.</p> <p>The things that people were accused of, that they didn't even do</p> <p>she said to everybody 'this is a classic example of an anorexic monster' trying to manipulate.</p> <p>Feeling trapped</p> <p>Its only when people are forced that things go wrong.</p> <p>Facing Ultimatums</p> <p>'liberty based'/ Taking 'liberties' away</p> <p>Being Punished</p> <p>Experiencing staff patient interactions as purposefully punishing</p> <p>she'd make us have these double portions</p> <p>Using fears associated to food/eating to punish/subjugate/taunt patients</p>
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	<p>Controlling through body restriction</p> <p>Time as empty/unstructured: punishing</p> <p>Experiencing staff silence as cruel/rejecting</p> <p>Treatment as Torture</p> <p>Treatment as Trauma</p> <p>Embedding Anorexia</p> <p>Infantalisation as manifestation of contextual void of emotional nourishment</p>	<p>you weren't allowed to put your feet up, you had to sit there, feet forward, looking forward</p> <p>'Oh we can't help you.' We just had a member of staff who sat there staring at us.</p> <p>'hell hole'</p> <p>Vicarious terror: hearing force tactics on other patients.</p> <p>we could hear the girls in the acute screaming as they dragged them down the hall by their wrists and ankles.... It was so dangerous, because when they took her out, she was, they just left her in a pile in the hall</p> <p>'Tearing lovely people apart'</p> <p>"Inhuman, its disgusting"</p> <p>that place messed me up so much. I still have nightmares about that place</p> <p>I feel so much more messed up than I've ever felt because of my experience there</p> <p>these patients are forced back into a childlike state. And they're cuddling these teddy bears because that's all the love they are going to get in here.</p>
Deteriorating relationship with food	<p>Distasteful Food</p> <p>Deteriorating relationship with food</p>	<p>It didn't even resemble food</p> <p>my relationship with food has gone very downhill</p> <p>I can't touch fruit juice anymore. They seem to take</p>

	<p>Extreme Food practices within eating disorder services.</p> <p>Decontextualising meaning of food through ab-normal food practices.</p>	<p>(food) things to extremes in these institutions.</p> <p>I'd just think Why can't you just have normal food.</p>
Lack of containment	<p>Lacking support</p> <p>Managerial inconsistency</p> <p>Staff inconsistency</p> <p>Embedding Anorexia</p>	<p>Feeling unsupported through meals</p> <p>Conflict of approach to treatment between senior clinicians</p> <p>contradictory messages /rules</p>
	<p>Complying as a habitual personal characteristic</p>	<p>I always complied. That's just me. I don't like breaking the rules. I don't like going against anybody or doing the wrong thing</p>
Resistance	<p>Undoing treatment</p>	<p>Associating Anger as cause of relapse</p> <p>Body hatred./Self revulsion as cause of relapse</p>
Withdrawing Trust (Rejecting interdependence)	<p>Reinforcing self-reliance</p> <p>Drawing on peer support</p> <p>Compliance as convincing/ effective strategy of pretence</p> <p>Compliance as shutting off</p>	<p>Developing expectation of self-reliance for recovery in response to distrust of Treatment Services</p> <p>Patients relying on other patients for support through meals.</p> <p>They just assumed I was doing really really well. I wanted to pretend that everything was ok... 'I've had an epiphany, and I want to recover'</p> <p>I just shut off all the human</p>

	<p>human instincts</p> <p>Dissociating emotional experience: as strategy for discharge.</p> <p>Compliance as self-abandonment/self-annihilation.</p> <p>Confounding treatment: performative binge eating</p>	<p>instincts and all feeling just so I could get home</p> <p>I felt as if I needed to appear as if everything was all right just so I could get home, but I was basically dying inside.</p> <p>I ate almost the entire pudding in front of her.</p>
Collaborative approach	<p>Desiring humane approach: feelings valued, being listened and responded to</p> <p>Relational honesty emerging from collaborative approach</p> <p>Valuing patient autonomy.</p> <p>Collaborative approach as non-coersive.</p>	<p>I think the focus should be more on you as a person Take on how you are feeling, as a person, take on what you say</p> <p>The thing I really do appreciate about this place is that they really do take into account what you say</p> <p>I feel I can try and be more true to myself because they really do try to take on what you say and they really do try to work with you.</p> <p>they realise that it's got to come from you. That forcing isn't the way forward</p> <p>I wish there were more places like this</p>
Treatment as Self Discovery	<p>Treatment focus on developing the person.</p> <p>A holistic approach (supporting psychological integration)</p>	<p>work on you as a person more than anything else which I think is so important. It is a really holistic approach</p> <p>helping people to live better lives</p>

	<p>Envisioning effective treatment as place of self-discovery.</p> <p>Asserting necessity for psychological development before and alongside physical recovery.</p>	<p>“What they need help with is finding themselves as a person”</p> <p>And I have really got to work on myself, as a person, before anything else.</p>
Experiencing containment	<p>Expressing emotion upon encountering kindness.</p> <p>Treatment environment of kindness immediately challenging core belief of unworthiness.</p> <p>Fearing relational openness/emotional vulnerability</p> <p>Flexibility in time boundaries demonstrative of emotional containment and genuine care.</p> <p>Staff Cohesion sharing humanistic ethos</p> <p>Managerial consistency/communication Demonstrating existence of patient voice.</p>	<p>I burst into tears - because I wasn't expecting them to be so lovely, because I was terrified</p> <p>I can also get my head around that I am struggling, maybe I am worthy of needing help</p> <p>I'm really afraid of expressing how I really feel</p> <p>There's no time limit... they really try to work with you and support you. It's really lovely that they care so much.</p> <p>All the staff seem to really care about you as a person...as an individual</p> <p>It amazed me, when I have my reviews my consultant here, she remembers exactly what I said the week before... I'm like – oh my god you listen to me!</p>
	<p>Ambivalence towards recovery</p> <p>Determining autonomy in considering desire for recovery.</p> <p>Identifying specific</p>	<p>I'm not sure I even want recovery...</p> <p>if I ever get there then its got to be in my own time.</p>

	<p>needs/limits/ setting boundaries</p> <p>Emphasising the need to live with autonomy.</p>	<p>I know now that you can't fast track recovery</p> <p>Identifying a wall of weight tolerance</p> <p>Viewing many treatment services as detrimental for recovery</p> <p>Rejecting group identification of being anorexic/ Seeking non-ill social environment</p> <p>I know that I can't be forced to be something I am not, and that I've got to do what I want to do , because I have always tried to do things that pleases other people</p> <p>Recognising lack of autonomy as a central relational problem</p> <p>Rejecting external time pressures</p> <p>'Doing for myself'</p> <p>Self-determining the way</p> <p>Harnessing self-responsibility</p> <p>'Taking each day as it comes'</p>
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Saturating Categories: Integrating Interview 11 (Karen) into Tentative Categories

Standardisation	Criticising Exposing environment	<p>Criticising lack of privacy in hospital</p> <p>Food disgust</p>
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Subjugation	<p>Facing Ultimatums as Initiation</p> <p>Context exacerbating fear and vulnerability</p> <p>Understanding compliance as self-deception.</p> <p>Purposefully Seeking and selecting the ‘most horrible’ treatment context</p>	<p>‘feeling like a rabbit in the headlights’</p> <p>At the moment I don’t trust myself. I’m always compliant.</p> <p>I didn’t realise how punishing it felt anyway</p>
	<p>Objectification</p> <p>Medicalisation associated to a lack of staff engagement or care</p>	<p>Nobody said, are you ok. It was just all very clinical, it was all just about numbers.</p>
Resistance	<p>Food replacing experience of powerlessness/lack of control. (Choice to eat or not to eat)</p> <p>Resisting Treatment being accepted as part of the process (p5)</p>	<p>Complying as Strategy for discharge</p> <p>Qu @ concept of control</p> <p>If I feel like I don’t have control over any aspect of my life, then I revert to food.</p>
Collaborative approach	<p>Collaborative approach associated to voluntary contract.</p>	
<p>Treatment as self-development</p> <p>(Viewing as or seeking for)</p>	<p>Gaining self-awareness through relationship</p> <p>Differentiating between illness mind and actual self. – as evidence of recovering.</p>	<p>it took a lot of talking to people. Just talking. ... it was definitely quite a slow process. Figuring out, yes, there was something wrong.</p> <p>I feel so much better now... I can recognise what’s me and what’s the illness</p>

	<p>Holistic approach fostering alternative positive identities and activities</p> <p>Gaining permission to enjoy life</p>	<p>encouraged to start playing the guitar again</p> <p>now that I am allowed to do something I enjoy</p>
Experiencing containment	<p>Releasing time pressure. Allowing internal sensitivity and attention to emotional process.</p> <p>Physical surrender</p> <p>High Staff patient ratio Staff , low turn over, Creating 'nice environment' sense of Safety.</p> <p>Developing trust to share emotional experience</p> <p>Emphasising centrality of trust. Associating trust to overarching ethos of treatment service.</p>	<p>Feeling understood</p> <p>I feel exceptionally lucky that I ended up here. That I've had the time here that I have. because there's so much support here. Its been a slow process. I've been allowed to feel my way.</p> <p>'Honey moon period'</p> <p>here you are kind of held... I was mentally and physically exhausted, I couldn't do it anymore, I remember being so relieved coming somewhere where somebody else is going to take that responsibility</p> <p>Developing trust with therapist to talk about deepest and darkest feelings.. learning to share</p> <p>Trust is a big issue. And learning to trust. And that's the same for everyone. And learning its ok. These people only have your best interest.</p>
Qu of Diagnosis	Identifying utility of diagnosis	Lack of diagnosis – encouraging denial of ED.
Lack of containment	Criticising use of Agency	Agency staff - They do a

	<p>Staff</p> <p>Lack of understanding Failure of inter-staff communication/managerial consistency</p> <p>Enabling the illness to take control, express itself.</p>	<p>lot more harm than good to be honest</p> <p>‘didn’t have a clue’ Absolutely awful. hadn’t been told enough information don’t know how to do supervision</p> <p>That makes our journey harder, coz that feeds it. She saw that opportunity, the illness will grab it</p>
	<p>Ambivalence towards recovery</p> <p>‘Doing it for oneself’</p> <p>Developing a fear of the illness.</p> <p>Finding the part of self that wants recovery</p> <p>Identifying unique needs/direction for personal growth</p> <p>Willingness to engage in Recovery achieved through relational support</p>	<p>I’m more interested in how I can cope more healthily. How I can accept to that its ok to be ok.</p> <p>All the conversation’s I’ve had here and the support has helped me to come to the conclusion that I don’t want to exist, I want to live.</p> <p>I’ve been given... gentle encouragement, and the time to process things recovery can be so delicate</p>
	<p>‘Readiness to Recover’</p>	<p>If I hadn’t come here I might have been one of those people who aren’t ready to recover</p>

Appendix 22: Overview of the Analytic Process



Appendix 23. The position of compliance

Reflecting a model of behaviour typically attributed to or encouraged in young females, participants declared:

I've always complied. (Iris)

Everything in my life has always been about being this good girl... trying to please everyone. (Cathy).

I don't want to make things difficult for people. (Fiona)

These accounts present a re-articulation of both stereotypical femininity where “girls are made of...passivity” (Wetherell, 1986:79, citing Bardwick & Douvan, 1971) and psychiatric characterisations of typical anorexics as demonstrating 'a need to please and...be liked' (Malson & Ryan, 2008:9, citing Bardwick & Douvan, 1971; also see Crisp, 1984, 1980; Lawrence, 1984) or tendency to “suppress their own needs in order to meet the needs of other” (Pemberton & Fox, 2011:226).

Representative of a broader manifestation of society's subjugation of women, people suffering from AN sometimes appear to identify with 'self-effacing' 'self-sacrificial' or 'accommodating' qualities of character, as if symbolically, the act of denying themselves the right to eat symbolised their desire to take up less space, fewer resources, and to minimise their impact on others. These meanings underlying self-starvation were repeatedly voiced in participant's statements about feeling intrinsically 'undeserving' and 'unworthy' and directly associated to their lack of self-permission to eat. However, the act of compliance appears to

show how patients drew on aspects of the ED associated with fulfilling these social expectations of femininity to conform and fulfil the demands of treatment, arguably presenting AN as a subversive confrontation towards socially endorsed behaviour for females.

Appendix 24. Gaining Permission for Recovery

Participants emphasised their need to ‘gain permission’ from treatment in claiming their *right* to fight their illness. Treatment’s position of authority was harnessed by patients as a means to authorise themselves to recover, which again illuminates the relational dimension of self-empowerment. Treatment’s function to grant the patient’s ‘real self’ permission to grow, to thrive, to need, to express and challenge its position of being ‘forbidden’ or ‘undeserving’, appeared to endorse and ‘build up’ the part of self that wished to be free. This notion of permission resonates with Orbach’s (1986) sociological conception of AN, in which she argues that AN emerges in response to western and other societies negation or minimisation female needs and desire. “What is needed, at the psychological and social level is an acceptance of female desire as legitimate in which needs for contact and other emotional or physical ‘appetites’ can be acknowledged and the acceptability of their satisfaction established” (Orbach, 1986:192,170,141). Orbach (1986) proposes that “in allowing herself to feel and to act, she reverses some of the key features of socialisation towards femininity... she becomes a person with legitimate desires and demands which she can now openly express” (p.179-80).

This understanding of ED’s presents the necessity of inhabiting a position of social resistance to undergo an effective recovery process. Speaking of Laing’s philosophy, Vice (1992) writes: “the sympathy, support and acceptance necessary to conclude the voyage of madness successfully is predicated upon a realisation that the voyage itself is made necessary by the alienating process of socialisation” (p.125). From this perspective, treatment’s function may be to empower the patient to resist the forms by which they have been subjugated by society and to contest social pressures that undermine a woman’s legitimacy to

desire, need, or self-expression, which, as the ED condition exemplifies, fosters self-alienation and self-loathing.

Appendix 25. Being Believed In

The experience of being believed in by staff within the treatment context was found to deeply influence patients' ability to reposition themselves towards recovery. As Gergen (2015) articulates: 'how you identify yourself will largely depend not on your choice, but on the way you are represented in others talk' (p.54). This highlights the importance of staff's recognition of and belief in patients' personal resources in their ability to recover and to communicate this belief to the patients, no matter how hopeless the patient themselves feel about this possibility. Furthermore, this perspective challenges the clinically prevalent notion of AN as 'intractable' in which the clinician is advised to accept and work around the inevitability of a persevering illness. In 'feeding clinics', the 'doom and gloom' participants spoke of feeling 'once you're in there' highlights the relational impact of this clinical position. Literature emphasising the chronicity of the illness and the likelihood of the patient's inability to recover appears to overlook the importance and power of clinicians' belief in recovery.

Appendix 26. Website Statement of Treatment Outcomes

Our outcomes

- 93% of Adult EDU service users with Anorexia gained weight on discharge*
- Adult EDU service users with Anorexia increased their BMI by 2.8 on discharge*
- The proportion of Adult EDU service users with Anorexia and a healthy BMI of between 18.5 and 24.9, increased by more than 3 times on discharge compared to admission*
- 83% of service users demonstrated an improvement upon discharge from therapy*

*Between October '14 and September '15

(Priory Group, Adult Eating Disorders Services)

Appendix 27. The Employment of Temporary Staff

Within this study, the routine employment of temporary staff to perform nursing care was found to generate staff/patient relations defined by mutual anonymity, reinforcing patient experiences of depersonalisation within these contexts and magnifying their difficulty of 'reaching out for support'. Most participants formed the impression that temporary staff were inexperienced, ill-informed or otherwise ill-equipped to provide appropriate or adequate care to patients and this was directly related to the view of treatment as an unsafe environment. Managerial complications appeared to exacerbate this experience. Alongside issues with understaffing (also see Ramjan, 2003) and staffs' lack of physical or emotional availability, a climate of stress, general chaos and operational overwhelm all contributed to patients' experience of a lack of safety and their self-protective decision to withdraw any previous willingness to communicate openly with staff. Having reviewed research highlighting the importance of therapeutic relationships within inpatient contexts, this study identifies that the practices of employing temporary staff appear to inhibit the development of meaningful therapeutic relationships and thus negatively impinge on patients' recovery process.

Appendix 28. The Provision of Psychotherapy within Inpatient Settings.

Providing AN patients psychological therapy is supported within psychiatric literature as unnecessary and even, counter therapeutic during the inpatient period of weight restoration. Literature produced on AN by leading figures such as Professor Crisp (1980) and Russell, (1970; 1980) seems to have informed the practice of delaying psychotherapy provision on the basis that anorectics reduction in the intake of food produces a progressive decline in intellectual capacity, whilst weight-restoration is understood to ‘switch on’ hormonal development, enabling the anorexic “to get back in touch with ‘her more natural psychological self” (Crisp et al., 1980:140, 84-5, 103; Crisp and Fransella, 1979:80 cited in MacSween, 1993:30). The authors subsequently advise that treatment should first ‘re-expose [the patient] to the phobic situation’ (Crisp 1967:716), which is *herself* at normal adolescent body-weight” (Fransella and Crisp 1972:395) before providing psychotherapy.

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